

Fatal Choices:

COVID-19, Nursing and the Tragedy of Long-Term Care

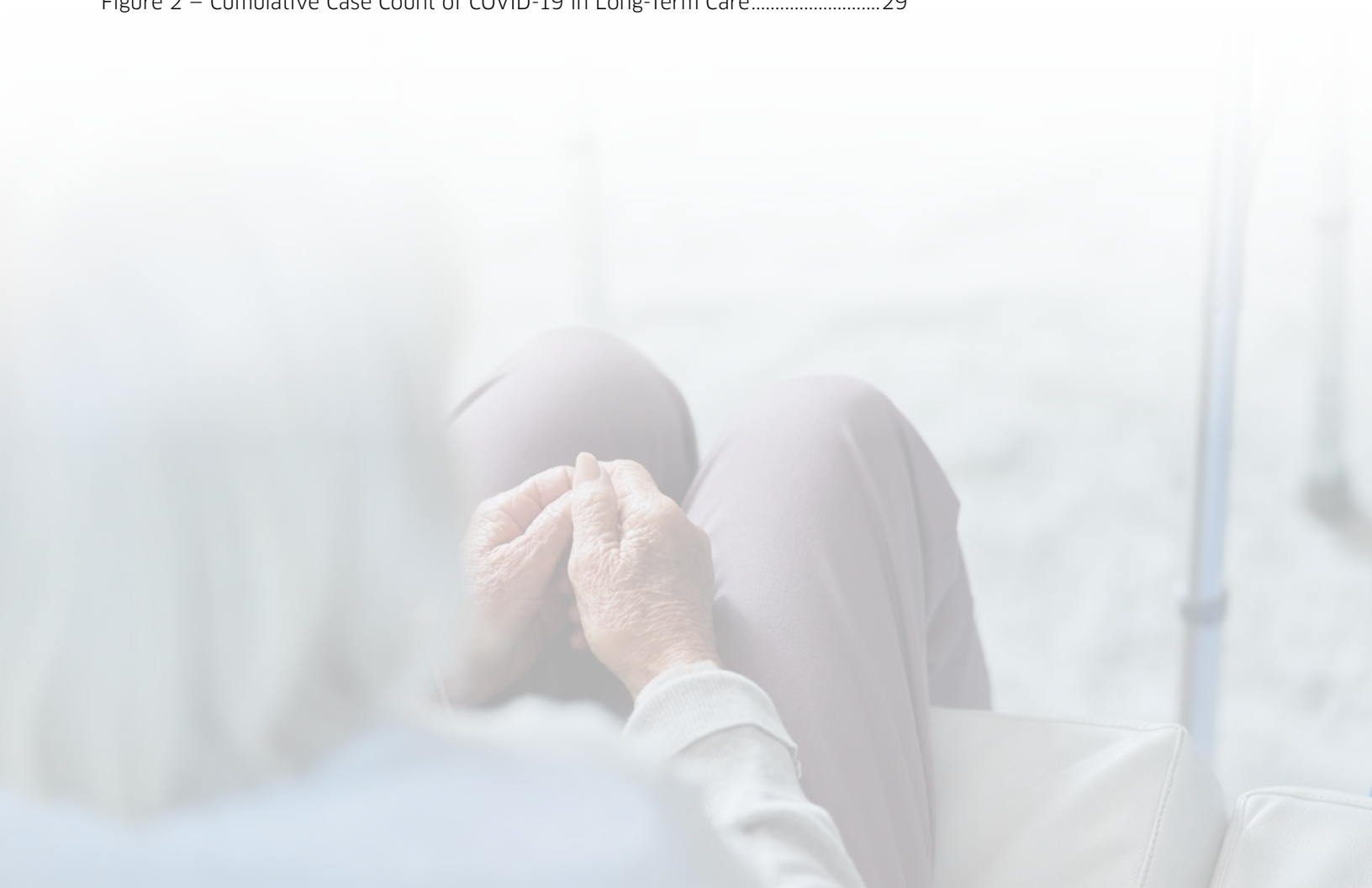
By Mario Possamai

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Acknowledgment and Dedication

This report is dedicated to registered nurses in long-term care. Their courage, dedication, leadership and integrity has been a source of light and inspiration amid the darkness of the worst public health disaster in a century. They have been battle-tested by an insidious new pathogen and by employers who refused to adequately protect staff and residents unless ordered to do so by courts and arbitrators. We owe them a huge debt of gratitude.

This report is also dedicated to the victims of COVID-19, their families, friends, colleagues and communities.

In the SARS Commission final report, Justice Archie Campbell wrote:

“SARS taught us lessons that can help us redeem our failures. If we do not learn the lessons to be taken from SARS, however, and if we do not make present governments fix the problems that remain, we will pay a terrible price in the face of future outbreaks of virulent disease.”

It is a tragedy that we did not learn sufficiently from SARS to redeem Ontario's failures from the 2003 outbreak.

May the aftermath of COVID-19 be different. May the anguish and suffering of COVID-19 not be forgotten.

This report is also dedicated to my friend and mentor, Justice Archie Campbell. Assisting him on the SARS Commission was an honour and the highlight of my career. “Archie,” as I had the honour to call him, was very ill as he completed the Commission's final report in December 2006 and would die a few months later. I have never witnessed such courage and grace under fire. As no one else I have met, Archie lived up to the dictum of Marcus Aurelius, one of his favourite authors whom he read in the original Latin: “Live a good life.”

“It takes a village to raise a child,” goes a wise African proverb. It also takes a village to prepare a report like this one under an extremely tight deadline.

Beverly Mathers, CEO of the Ontario Nurses' Association (ONA), provided valuable advice and comments on the final drafting of this report. Her support throughout this project was greatly appreciated.

I would like to thank Sharan Basran, Senior Executive, Legal, at ONA, for her unflagging support, commitment and wise counsel. Her insights in drafting and reviewing the report were indispensable. Throughout COVID-19, Sharan has

developed, overseen and executed with distinction, a complex legal strategy that has made a significant difference in keeping registered nurses, residents and other health care workers safe in long-term care. She has inspired the highest standard of professional performance in her colleagues, and in myself.

I would also like to thank Nicholas Baxter, a thoughtful member of the ONA legal team who has been invaluable in drafting, researching and editing this report. His legal learning and judgment have made a huge difference. I could not have completed this report without his enormous dedication, energy, commitment – and infectious sense of humour.

A special thanks to Nicole Butt, Legal Counsel and Manager of Litigation, and Marcia Barry, Senior Legal Counsel, at ONA. They provided invaluable advice and input into a variety of ongoing and historical issues in long-term care and were generous with their time in reviewing the report. Nicole and Marcia embody the legal profession at its best – as guardians of justice, striving for a more just society.

My thanks to Dave Campanella, ONA's economist and data analyst, who provided a rigorous analysis of COVID-19's grim toll and the data that underpinned this report.

My thanks to Tanya Beattie, RN, BScN, MPA, Research/ Nursing and Health Policy Officer at ONA, and Christina Pullano, RN, BScN, MN (student) for their invaluable insights into the history of the nursing profession and its role in long-term care.

My thanks to Vicki White, ONA's librarian, who was indefatigable and meticulous in her research.

When completing a report of this nature in the face of an extremely tight deadline, a huge burden falls on to the shoulders of editors, graphic artists and proofreaders. The ONA editing and graphics team is second to none. I have rarely seen a team perform so well under so tight a deadline. I owe a debt of gratitude to: Holly-Ann Campbell, Executive Lead, Communications and Government Relations, Ruth Featherstone, Communications Officer, Melanie Levenson, Communications Officer, Katherine Russo, Communications Officer, and Shannon Balmer, Labour Relations Assistant.

Thanks also to the design team from ImageStudio Creative Communications Inc.: Deana De Ciccio, Art Director/Graphic Designer and Brandon Brind, Creative Director/Principal.

Executive Summary

A Litany of Failures

This report examines the tragedy of COVID-19 in long-term care in Ontario through the lens of the SARS outbreak of 2003 and the subsequent findings of the SARS Commission; the perspectives of registered nurses; the experiences of jurisdictions that learned from SARS; and the recommendations and warnings of unions and worker safety experts that were repeatedly ignored.

Ontario and its long-term care sector have paid a heavy price in preventable COVID-19 death and disease because of a litany of failures to both heed the preparedness and containment lessons of the 2003 SARS outbreak, and fix the sector's endemic problems. These avoidable failures constituted a series of fatal choices, creating an environment ready-made for a novel pathogen to run rampant, and setting off the worst public health crisis in a century.

Among the many failures, Ontario ignored the key finding and recommendation of Justice Archie Campbell's SARS Commission: the precautionary principle. When facing a new pathogen with unknown characteristics and transmission dynamics – especially when evidence of airborne spread is growing – the principle calls for erring on the side of safety and caution.

Ontario's failure to heed the precautionary principle had destructive knock-on effects that crippled the pandemic response in long-term care – and in the province at large. Registered nurses and other health care workers were forced to wear surgical masks and not N95 respirators. This meant they weren't properly protected against a pathogen that most everyone, including international and national public health agencies and scientists, now acknowledges spreads through the air. Airborne containment measures such as ventilation and air purification – vital sources of protection in long-term care, schools and workplaces – were put on the back burner.

The heartbreaking breadth of COVID-19 in long-term care was not inevitable. The now widely accepted solutions to the problems revealed by COVID-19 and in long-term care reflect Justice Campbell's recommendations; the clinical judgment of nurses; the recommendations of unions and worker safety experts; and/or the long-term sector-specific solutions put forward by numerous investigations over the past two decades. This indicates that, at the very least, the worst of COVID-19 could have been avoided.

Ontario vs. SARS Peers

Ontario and its SARS peers – China, Hong Kong and Taiwan – recorded a combined 94.8 per cent of all SARS cases, 94.0 per cent of its deaths, and 91.7 per cent of all cases involving health care workers. These four jurisdictions had the opportunity to learn from the experience of SARS and prepare for a future pandemic.

The evidence suggests that China, Hong Kong and Taiwan leveraged the lessons of SARS to both effectively prepare for and respond to COVID-19. Ontario did not. The tragic result: As of January 23, 2021, Ontario had more COVID-19 cases (210,276) than China (100,298), Hong Kong (10,321) and Taiwan (895) combined.

When the pandemic struck, Hong Kong took a precautionary approach and regarded COVID-19 as an entirely new pathogen. It acted decisively to protect its long-term care residents and staff, shutting its care homes to most visitors. Nearly everyone in Hong Kong was wearing a mask by mid-February 2020 to limit community spread of the virus. As of November 29, 2020, Hong Kong, with more than 76,000 nursing home beds, had seen 30 resident COVID-19 deaths. Ontario has about the same number of long-term care beds: 77,257. As of that date, Ontario had 2,301 long-term care resident deaths in both the first and second waves, plus 10 health care worker deaths.

Starting in late January 2020, China protected its health care workers at an airborne level. It suffered only one wave of COVID-19, with the number of cases remaining relatively stable since life began returning to normal during the summer. As of May 8, 2020, 3,514 health care workers with COVID-19 were clinically or laboratory diagnosed in China, about 4.4 per cent of all Chinese COVID-19 cases. Most of these cases occurred before China implemented airborne precautions in late January 2020.

Through the Lens of Registered Nurses

This report examines what went wrong and what could have gone right in Ontario's long-term care system through the lens of the experiences and clinical judgment of registered nurses. It is anchored in more than 200 interviews with registered nurses; numerous declarations submitted by them in legal proceedings; case studies from the first and second waves; and a survey by the Ontario Nurses' Association (ONA) of its members in long-term care.

Despite repeated documented efforts to silence and disregard the voice of registered nurses, they have borne witness to conditions and failures in long-term care that are unworthy of our seniors, their families, their caregivers, and their communities.

Because of their clinical experience in long-term care, registered nurses have Ontario's most extensive first-hand empirical experience with COVID-19 among senior health care professionals. Yet, as documented throughout this report, their warnings and insights have been ignored.

Since the start of the pandemic, registered nurses, their union and worker safety experts were proved right about COVID-19's airborne potential and the importance of the precautionary principle; public health and its supporters in infectious disease and epidemiology were decidedly wrong. Registered nurses know what is needed to improve long-term care, and this report seeks to give a voice to those solutions.

Higher Risk to Health Care Workers

The failure to implement the precautionary principle has had direct negative consequences on health care workers and long-term care residents. Ontario health care workers face a higher risk of catching COVID-19 than the general population. While provincial data is incomplete and has significant gaps, a preliminary analysis of the available data suggests that health care workers as a whole may be three times more likely to be infected with COVID-19 than the general population.

Health care workers in long-term care appear to face an even higher risk. Comprising about one-third of health care workers infected with COVID-19 in Ontario (5,556 vs. 16,204 as of January 23, 2021), health care workers in long-term care are about twice as likely to catch COVID-19 as health care workers as a whole.

To better understand the impact and associated risk factors of COVID-19, ONA conducted a survey of its members in long-term care. Among all respondents of the survey, 35 per cent identified themselves as racialized. Among respondents who worked at a long-term care home during an outbreak, 63 per cent identified as racialized. Racialized respondents were more likely to work in an outbreak home with 11 resident infections or greater (53 per cent) compared to non-racialized respondents (20 per cent).

In addition to infection rates, COVID-19 has had a fundamental impact on the mental health of registered nurses. Just over half (51 per cent) of respondents to the ONA survey of its long-term care members reported experiencing a symptom of post-traumatic stress disorder, including depression, anxiety, sleeplessness or nightmares. For registered nurses who experienced a large outbreak, this percentage jumped to 61 per cent.

Hubris and its Consequences

Ontario ignored the repeated warnings of registered nurses, unions, and worker safety experts that COVID-19 could spread through the air, abandoning the precautionary principle at the dawn of the pandemic in March 2020.

Over and over, ONA warned the Ontario government about the risk COVID-19 poses to the health sector, and the need for the precautionary principle, including in face-to-face meetings with Health Minister Christine Elliott in January 2020, and in February 2020 sessions of the province's COVID-19 labour advisory table.

Despite this, in March 2020, the Ontario government decided, on the basis of insufficient evidence, that COVID-19 did not, and could not, be an airborne pathogen. It downgraded the level of personal protective equipment that nurses and other health care professionals needed to protect themselves against COVID-19 from N95 respirators to a simple surgical or procedure mask.

The March 2020 decision was guided by hubris – often defined as exaggerated self-confidence – rather than humility. In a barbed public campaign supporting the downgrading, Ontario's infectious disease and public health leaders relied on the outdated "large droplet" disease transmission model, which is based on 1930s research when instruments were too primitive to detect tiny aerosols and ignores the modern science of airborne spread.

Month after month, as more and more evidence demonstrated COVID-19's airborne risks – and the inadequacy of the "large droplet" model – Ontario's infectious disease and public health leaders continued to stubbornly resist changing course and better protecting

residents and health care workers in long-term care. They chose medical orthodoxy over science and persisted in advising that surgical masks were sufficient protection for health care workers.

ONA sought to put the control of personal protective equipment back into the hands of registered nurses. It filed a court injunction against four long-term care homes for poor infection control practices and locking away N95s. Justice Edward Morgan found Public Health Ontario did not identify that the March 2020 guidance on downgrading was influenced by issues unrelated to science. He found that the decision was, in part, based on shortages of N95 respirators for health care workers, shortages for which the province itself was responsible. This action risked bringing science and public health into disrepute.

In the SARS Commission report, it was recognized that Canada did not have a domestic capacity to produce N95 respirators, and Justice Campbell recommended that Ontario build up a strategic reserve. A stockpile of 55 million N95s was established in the years after SARS, but it was allowed to expire and was largely destroyed in 2017 without being replaced. Ontario said it was waiting to establish a new stockpile system before replenishing the reserve, a process that was not yet completed by the end of 2020. This left Ontario's personal protective equipment cupboard bare entering COVID-19.

Ontario's Chief Medical Officer of Health, Dr. David Williams, had a direct line of sight into the stockpile problem. He headed the division responsible for the stockpile from 2018 to August 2020. On his watch, his division destroyed N95 respirators without replacing them, and decided to study the stockpile problem instead of fixing it.

Moreover, Dr. Williams failed to use his independence and powers to warn legislative assemblies and the public about Ontario's lack of pandemic preparedness. Instead, at the dawn of the pandemic, Dr. Williams inexplicably said Ontario was "better prepared because of the SARS experience." Ontario was anything but ready for COVID-19.

ONA Filled Void of Government Inaction

Government decision-making and inaction had dire consequences for long-term care workers and residents. Employers, relying on government directives and guidance that ignored growing evidence of COVID-19's airborne risks, argued inexplicably that it could only

be spread through large droplets, unless an aerosol generating procedure was being performed. In some cases, employers denied health care workers N95 respirators and other personal protective equipment by locking them away in inaccessible locations.

Employers also frequently failed to implement basic infection control practices, such as staff and resident cohorting and isolation, to limit the potential spread of COVID-19. At one home, Anson Place, management asserted that drawn curtains between residents' beds in a four-bed ward room would be sufficient protect residents from becoming infected.

As the pandemic unfolded, it became increasingly clear that the Ministry of Labour would not step in and make the necessary orders to protect workers. Consequently, ONA was forced to take action, address an emergency situation, and fill the void of government inaction by:

- Holding government, nursing homes and public health accountable through advocacy with government and nursing homes, and taking legal action, including seeking court injunctions;
- Putting forward urgent solutions to protect residents and health care workers that were often rebuffed by nursing homes and continue to be resisted; and
- Ensuring that collective agreements, public health directives and workplace safety laws were enforced in nursing homes.

It is highly troubling that a union was forced to do what government and nursing homes are duty-bound, mandated, funded and expected to do. As one legal expert noted: "In what world is a court order needed to require employers to provide front-line health care workers with the personal protective equipment that they, in their professional judgment, relying on best practices and government directives, determine is needed to perform their jobs safely?"

Solutions

Change for long-term care starts by listening to the voices of registered nurses, who have the primary supervisory responsibility in long-term care, and have had the greatest direct experience in treating COVID-19 patients. Historically, registered nurses are not seen as professionals who receive rigorous education and have valuable clinical experience. It is troubling that this has persisted into COVID-19. Too often, they are not regarded as clinicians with insights on par with those of physicians and other members of the health care team.

Echoing the research and reports on long-term care for the past three decades, registered nurses have called for transformation by government and employers to finally address long-term care's long-standing staffing issues. The current staffing levels are unsafe for workers and residents, and an urgent plan implementing immediate recruitment and retention initiatives is required.

The SARS report documented case after case of registered nurses being afraid to speak out about unsafe conditions in long-term care because they did not have sufficient legal protection to speak out. The recommendation of whistleblower protections from the SARS Commission was never implemented, and registered nurses were fearful to speak out about what they and residents were experiencing.

Moving forward the priorities of long-term care must be about quality of care and safety, not profits.

Absence of a Domestic NIOSH

Justice Campbell recommended that just as the National Institute for Occupational Safety and Health (NIOSH), the main U.S. federal agency responsible for worker safety research and investigation, is part of the Centers for Disease Control and Prevention (CDC), so Ontario should have a well-resourced agency focused on worker safety research and investigation, and on integrating worker safety and infection control.

Justice Campbell believed that a domestic NIOSH would ensure that decision-making on precautions for health-care workers and residents was:

- Based on a multi-disciplinary community of experts, including registered nurses, infectious disease, and health and safety experts;
- Reflected the clinical experience of registered nurses; and
- Did not compromise the safety of health care workers and the public while waiting for scientific certainty and was thus guided by the precautionary principle.

However, this recommendation was ignored, resulting in Ontario having no organization that certifies N95 respirators. Ontario manufacturers' only option is to go to NIOSH in the United States for N95 certification.

Because NIOSH has put foreign certification requests at the back of the queue, Ontario manufacturers who entered the personal protective equipment market are left in limbo.

The lack of a domestic NIOSH has meant that Ontario lacked the scientific ability to develop guidance and best practices on the personal protective equipment supply chain, including storage, replenishment, distribution and management.

Conclusion

Mariann Home, a non-profit, 64-bed facility in Richmond Hill, north of Toronto, has demonstrated that it was possible for all long-term care facilities in Ontario to have done as well as the province's SARS peers in protecting their residents and workers. None of its residents tested positive. One staff member tested positive but was not the source of any spread in the facility. What makes this so remarkable is that Mariann Home is an old facility rescheduled for development in 2025. It has one ward room with four residents. The rest of its residents are in semi-private rooms.

Mariann Home made good choices while, in contrast, leaders of Ontario's public health system and of too many nursing homes made bad choices before COVID-19 struck – leaving Ontario and far too many long-term care facilities unprepared for a pandemic. Registered nurses, residents and other health care workers suffered the consequences of this poor decision-making.

The tragedy of COVID-19 in Ontario is that it did not have to be this bad. It is one thing to suffer through a major calamity for which there was no possibility of mitigation. It is quite another to do as Ontario did, knowing what needed to be done – thanks to the detailed findings of Justice Archie Campbell's SARS Commission and the myriad investigations into long-term care – but doing far too little to prepare for and contain a once-in-a-century disaster like COVID-19.

History will not be kind if we allow the trauma and anguish of COVID-19 to have been in vain and to fade unredeemed into a distant memory. We owe it to future generations to do nothing less.

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Chapter 1

COVID-19 – A Preventable Tragedy

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Introduction: History Repeats Itself

“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.”

This warning – penned by a gravely ill Justice Archie Campbell in late 2006 as he finished the SARS Commission’s final report, just months before his death – haunts Ontario’s COVID-19 response in long-term care.

COVID-19 revealed that Ontario disregarded Justice Campbell’s recommendations and did not fix the problems disclosed by the SARS outbreak in 2003. Some 8,096 SARS cases and 774 deaths were recorded around the world, including 375 cases and 44 deaths in Ontario, the worst hit jurisdiction outside Asia.

Justice Campbell’s major finding – as relevant to COVID-19 as it was to SARS – is the precautionary principle. When facing a new pathogen with unknown characteristics and transmission dynamics, it calls for erring on the side of safety and protecting health care workers at the highest levels with airborne precautions, including N95 respirators or higher.

“As a nurse, the first defence is precautionary measures,” said one registered nurse in long-term care. *“Don’t wait until everyone is sick.”*

In a troubling example of hubris, Ontario ignored the warnings of registered nurses, unions and worker safety experts and ditched the precautionary principle in March 2020, claiming on the basis of insufficient evidence, that COVID-19 did not, and could not, spread in the air.

This had a destructive knock-on effect that crippled the pandemic response in long-term care – and in the province at large. Registered nurses and other health care workers weren’t properly protected against a pathogen that most everyone now realizes spreads through the air. Airborne containment measures like ventilation and air purification were put on the back burner.

Registered nurses, their union and worker safety experts were proved right about COVID-19’s airborne potential and the importance of the precautionary principle;

public health and its supporters in infectious disease and epidemiology, were decidedly wrong.

“Nothing was learned” from SARS, said one registered nurse. *“It’s stunning. They went the opposite way. I am angry because I am watching in real time as they put everyone in harm’s way.”*

Adding to the misery, Ontario also did not fix the myriad of problems in long-term care that have been studied repeatedly, including insufficient staffing, unsafe staffing levels for registered nurses, overcrowding, underfunding, outdated infrastructure, including ventilation systems, and in extreme cases, infestations of rodents and insects.

“The issues are not new,” said one registered nurse in long-term care. *“They have been long-standing for years. Personally, I am angered that this is what had to happen to make people pay attention.”*

Since the late 1990s, these problems have been the subject of at least 13 investigations, including two coroner’s inquests, and the provincial Long-Term Care COVID-19 Commission (LTC Commission). In each case, little, if any, substantive change generally occurred.

“Numerous reports have been written confirming what staff who work in long-term care have known, that long-term care is grossly inadequate, their staffing, given the acuity and care needs of the residents, which has grown year over year,” said Beverly Mathers, CEO of the Ontario Nurses’ Association (ONA).

Even the recommendations of the province’s own long-term care staffing study, released in July 2020, won’t be achieved until 2024-2025. Commenting on this, the LTC Commission has stated:

“The ministry’s Long-Term Care Staffing Study, released in July 20, identifies the best path forward. Further “study” of the Study is not necessary. What is required is the Study’s timely implementation.”¹

All these failures – to learn from SARS and to fix long-term care’s endemic problems – combined to create an environment in long-term care “ready-made for a respiratory virus to run rampant.”²

It did not have to be this bad. It is one thing to suffer through a major calamity for which there was no possibility to prepare and mitigate. It is quite another

to do as Ontario did, knowing what needed to be done but doing far too little to contain a once-in-a-century disaster like COVID-19.

Further, the tragic breadth of COVID-19 in long-term care was not inevitable. It is an open question of how much harm could have been prevented. The fact that most suggested fixes reflect either Justice Campbell's recommendations, or the sector-specific fixes put forward over the past two decades, indicates that, at the very least, the worst of COVID-19 might have been avoided.

The Lens of Registered Nurses' Experiences

This report examines what went wrong and what could have gone right in long-term care through the lens of the experiences and clinical judgment of registered nurses.

This report is anchored in more than 200 interviews with registered nurses, as well as declarations submitted by them in court and arbitration proceedings. They bear witness to conditions and failures in long-term care that are unworthy of our seniors, their families, their care givers, and their communities – and are a stain on the province of Ontario.

“We didn't have the damn tools,” said one registered nurse. *“They wouldn't give them to us. Everything was reactive.”*

Registered nurses have a unique vantage point on the COVID-19 disaster in long-term care. They're the hands-on leaders in nursing homes, supervising the work of other staff and overseeing the care of residents. And they've worked under the most difficult of conditions, caring for our most vulnerable.

Long-term care residents are typically seniors with chronic conditions that require the availability of 24 hour a day, seven day a week professional health care:

- The average age of residents in nursing homes is 85 or older.³
- Sixty-nine per cent have dementia and 87 per cent have some form of cognitive impairment (including dementia and other conditions such as stroke); 82 per cent require extensive assistance or are heavily dependent.⁴
- In addition to dementia and cognitive impairment, residents in long-term care also suffer from multiple and co-existing conditions, including diabetes, chronic heart disease, and lung or kidney disease.

- Many seniors in long-term care take 10 or more different medications.⁵

On each shift during COVID-19, registered nurses were in charge of addressing not only acute staffing shortages – sometimes a single nurse looked after as many as 200 residents – but also fixing everything from plumbing problems to infestations of rodents and insects, while responding to urgent phone calls from distraught loved ones and taking on the roles of funeral home staff who refused to enter their facility.

In a common sentiment, registered nurses said they were given all the responsibilities in long-term care, but none of the power.

Governments and long-term care owners turned a blind eye for too long on conditions in long-term care, relying on registered nurses to act to mend the unmendable – the many, deep, persistent, and long-standing cracks in long-term care:

“Under-resourced, over-worked and under-appreciated, [they] were the glue that held together this dysfunctional health sector with their courage and dedication. But even their courage and dedication could not hold back the tsunami of COVID-19. The result is that far too many health workers and far too many residents of the long-term care sector have been infected and died.”⁶

Adding to the calamity, the clinical judgment of registered nurses was ignored over and over. There's case after case of registered nurses recommending infection control protocols like cohorting and isolation measures, but their advice being repeatedly rejected.

In too many such instances, actions to protect residents and staff were not taken until the registered nurses' union – the Ontario Nurses' Association – obtained relief in court and in arbitration. Think of it: registered nurses, themselves, had to force employers and government to do what they were supposed to do to protect residents and all staff, not just themselves. Nursing has a long history of advocating for the vulnerable who cannot advocate for themselves.

Today's registered nurses in Ontario stand on the shoulders of Florence Nightingale, the founder of modern nursing, whose famous lamp shone a light in the mid-19th century on the suffering of wounded British soldiers in Crimea. She warned at the time:



We had very few staff at start of outbreak; same staff circulated on all units; exhaustion, many fell ill. –ONA member, survey response

“The three things which all but destroyed the army in Crimea were ignorance, incapacity, and useless rules; and the same thing will happen again, unless future regulations are framed more intelligently, and administered by better informed and more capable officers.”⁷

You could easily paraphrase that message and update it for COVID-19.

Indeed, there are important parallels between Florence Nightingale’s legacy and COVID-19. As the Dean of the Vanderbilt University School of Nursing, Linda Norman, has noted:

“The principles Florence Nightingale pioneered, first in the Crimean War, then in hospitals in England, form the bedrock of modern nursing. They are also the main defences against COVID-19 infection.

When Florence Nightingale arrived in the Crimea, she found horribly unsanitary conditions in the hospital wards. Soldiers were dying of disease, not their wounds. She promoted hygiene as a weapon to fight infection. So she had the barracks moved. She insisted on frequent hand washing, sterile surfaces, infection control, and fresh air. Those are still the methods employed to prevent transmission of COVID-19.”⁸

We’ll begin where Florence Nightingale herself focused during much of her career – on the numbers and on contextual comparisons:

“Mathematicians and data scientists revere Nightingale as one of history’s most important statisticians. She used data comparisons to find the causes of problems and to make forecasts.”⁹

A Terrible Toll

The long-term care sector – and the province as a whole – have paid, and continue to pay, a heavy price in death, disease, and economic and societal damage.

As of January 23, 2021:

- Ontario experienced 210,276 COVID-19 cases in the second wave (which began on September 1, 2020), roughly five times the 42,309 recorded in the first wave.

- It took 206 days for the provincial COVID-19 total to reach 42,309 cases in the first wave.
- It took just 144 days in the second wave to reach 210,276 cases.
- Cases among residents (7,918) and staff (2,918) in long-term care in the second wave have already exceeded the first wave totals of 5,936 cases among residents and 2,638 among staff.
- During the first wave, COVID-19 claimed the lives of 1,823 residents in long-term care. To date, the death rate of residents during the second wave has reached 1,560 and continues to climb.

Ontario health care workers appear to face a higher risk of catching COVID-19 than the general population. While provincial data is incomplete and has significant gaps, a preliminary analysis of the available data suggests that health care workers as a whole may be three times more likely to be infected with COVID-19 than the general population.

Health care workers in long-term care appear to face an even higher risk. Comprising about one-third of health care workers infected with COVID-19 in Ontario (5,556 vs. 16,204 as of January 23, 2021), health care workers in long-term care are about twice as likely to catch COVID-19 as health care workers as a whole. While more precise numbers are not publicly available, the health care workforce in long-term care in Ontario is said to total about 100,000 people, and comprise about 21 per cent of the total estimated provincial health care work force of 480,000.

Though these numbers are sobering, they’re likely an underestimate because of problematic provincial recording-keeping practices.¹⁰

Ontario’s numbers also may underestimate the broader impact of COVID-19 on long-term care because they do not include victims of pandemic-induced neglect or lack of care.

“They might not have died because of COVID,” said Dr. Samir Sinha, the director of geriatrics at Mount Sinai hospital in Toronto. “But they die because of starvation and dehydration.”¹¹

We will now compare Ontario's COVID-19 containment performance against our SARS peers, three countries – China, Taiwan and Hong Kong – that were also badly impacted by SARS. We also include South Korea. While not as badly impacted by SARS, it nevertheless closely studied SARS's impact on its neighbours and learned from that.

Ontario vs. SARS Peers

Many Ontarians may take comfort from the fact that the province's COVID-19 response is better than the United States. Tempting as that may be, the plain fact is our southern neighbour's COVID-19 performance is too low a bar to provide a useful comparison.

The United States, for example, ranked 94th in an analysis of the pandemic containment performance of 98 countries. Canada ranked 61st, better than the U.S., but still well behind the top three best performing nations: New Zealand, Vietnam and Taiwan.¹²

A more revealing comparison for Ontario involves the province's SARS peers, China, Hong Kong and Taiwan. These four jurisdictions recorded a combined 94.8 per cent of all SARS cases, 94.0 per cent of its deaths,¹³ and 91.7 per cent of all cases involving health care workers.¹⁴

As of January 23, 2021, Ontario had more COVID-19 cases (210,276) than China (100,298), Hong Kong (10,321) and Taiwan (895) combined.

China

On health worker safety, China has also significantly outperformed Ontario.

China suffered only one wave of COVID-19, with the number of cases remaining relatively stable since life began returning to normal during the summer.¹⁵ As of May 8, 2020, 3,514 health care workers with COVID-19 were clinically or laboratory diagnosed in China, about 4.4 per cent of all Chinese COVID-19 cases. Most of these cases occurred before China implemented airborne precautions in late January 2020.¹⁶

Unlike Ontario, China took a precautionary approach to safeguarding its health care workers. As one Chinese infectious disease experts explained:

“We have adopted a higher standard of protection in China, compared with the World Health Organization guidelines against COVID-19. The main difference is that we used fluid-resistant protective clothing (coverall) with long sleeve and conjoined cap rather than uncapped isolation garment, as well as use [of]

respirators (i.e. N95 or European Union standard FFP2) rather than medical surgical masks in wards dedicated for COVID-19 patients. A respirator, double rubber gloves, eye protection (i.e. goggles or a face shield), coverall and shoe covers were the standard equipment in contacting with COVID-19 patients in China.”¹⁷

This approach was so successful that, as the World Health Organization observed,

“Transmission within health care settings and amongst health care workers does not appear to be a major transmission feature of COVID-19 in China... among the HCW [health care worker] infections, most were identified early in the outbreak.”¹⁸

Hong Kong

In Hong Kong, 57 seniors died of SARS and the elderly were five times more likely to be infected than the general public. In the wake of SARS, new infection control measures were implemented, and long-term care facilities stocked three months' supply of personal protective equipment.¹⁹

When the pandemic struck, Hong Kong took a precautionary approach and regarded COVID-19 as an entirely new pathogen. In testimony before a British Commons committee, Adelina Comas-Herrera of the London School of Economics and Political Science noted:

“Their [Hong Kong's] infection control policies were based not on influenza but on SARS and perhaps that put them in a slightly better position to deal with this.”²⁰

When COVID-19 struck, Hong Kong acted decisively to protect its long-term care residents and staff:

“As COVID-19 loomed in late January 2020, Hong Kong shut its care homes to most visitors. Nearly everyone in Hong Kong was wearing a mask by mid-February to limit community spread of the virus. The government decided any infected care-home residents would immediately be sent to hospitals, and other exposed residents or staff removed from the facility to quarantine.”²¹

As of November 29, 2020, Hong Kong, with more than 76,000 nursing-home beds, had seen 30 resident COVID-19 deaths.²² Ontario has about the same number of long-term beds: 77,257. But, as of November 29, 2020, Ontario had 2,301 long-term care resident deaths in both the first and second waves, plus 10 health care worker deaths.

Taiwan

In Taiwan, which had been battered by SARS, not a single case of COVID-19 has been reported in long-term care.

Peishan Yang, a professor of social work at National Taiwan University, said part of the reason for that success was the country's bold and effective response to the pandemic in its early days. As of December 31, 2020, the country had fewer than 800 cases.²³

South Korea

South Korea, with a population of about 52 million, has also implemented aggressive measures to protect its elderly.

While South Korea was barely touched by SARS (three cases) – and, thus technically, not a SARS peer – it did learn from SARS and other major outbreaks:

“South Korea's COVID-19 policy was forged in the crucible of previous public health crises. In 2002, the SARS outbreak killed several hundred people in East Asia. In 2009, the H1N1 influenza, which likely originated in Mexico, spread to more than 1 million people globally and killed several hundred South Koreans. From these epidemics, South Korean public-health officials recognized the necessity of early testing and the importance of isolating new patients to prevent secondary infections. But 2015's Middle East Respiratory Syndrome, or MERS, created the playbook that the country has used to break the back of COVID-19... [MERS ran] rampant through the South Korean hospital system.”²⁴

As of December 31, 2020, residents in long-term care accounted for 316 of South Korea's 900 reported deaths from COVID-19²⁵ – about a tenth the total number of deaths of Ontario long-term residents.

A study on the South Korean experience in long-term care during COVID-19 concluded:

“By promptly isolating cases, applying extensive contact tracing, and placing at-risk people in quarantine early and efficiently, together with social distancing, avoiding contact with young cases, and proper personal protection, elderly people could be effectively protected from viral infection, despite a second rebound in young adults. South Korea has already set an excellent model for other countries to consider.”²⁶

Ontario

It is one thing to suffer through a major calamity for which there was no warning, no previous experience with its causes and effects, and no possibility to prepare and mitigate its deadly impact.

It is quite another to be like Ontario, having experienced SARS and the first wave of COVID-19, knowing what needed to be done to both prepare and contain a pandemic, but doing far too little.

In the second wave, Ontario has had more resident infections (7,918 vs. 5,936) and more health care worker infections (2,918 vs. 2,638) than in the first wave, and the second wave is not yet over.

As illustrated in Figure 1, there were indications early in 2021 that the second wave was intensifying. The Ontario COVID-19 Science Advisory Table observed:

“As of September 1, 2020, the beginning of the second wave in Ontario, the COVID-19 pandemic has been accelerating within LTC homes: 61% (4,321/7,090) of second wave resident cases and 68% (846/1,237) of second wave resident deaths have occurred between December 1, 2020 and January 14, 2021.”²⁷

Absence of Urgency

The glacial pace of Ontario government action during COVID-19 has also been a big problem. Consider, for example, how slowly Ontario rolled out directives on limiting long-term care staff to working at only one facility – a policy widely seen as important to preventing COVID-19 transmission.

On March 22, 2020, the government stated that long-term care facilities should restrict health care workers to one facility “whenever possible.” It wasn't until one month later in April that an order restricting employees to one facility came into effect. British Columbia, by contrast, put this limit in place on March 25, 2020.

A study in the *Canadian Medical Association Journal* that compared Ontario's long-term care response to British Columbia's concluded:

“During the first wave of the pandemic, British Columbia was faster than Ontario in responding to COVID-19, with actions to address public health support, staffing, and infection prevention and control. Leaders in British Columbia were more decisive, coordinated, and consistent in their overall communication and response.”²⁸

Figure 1 – First Wave vs Second Wave

Active Cases and Outbreaks in Long Term Care

April 24, 2020 – January 23, 2021

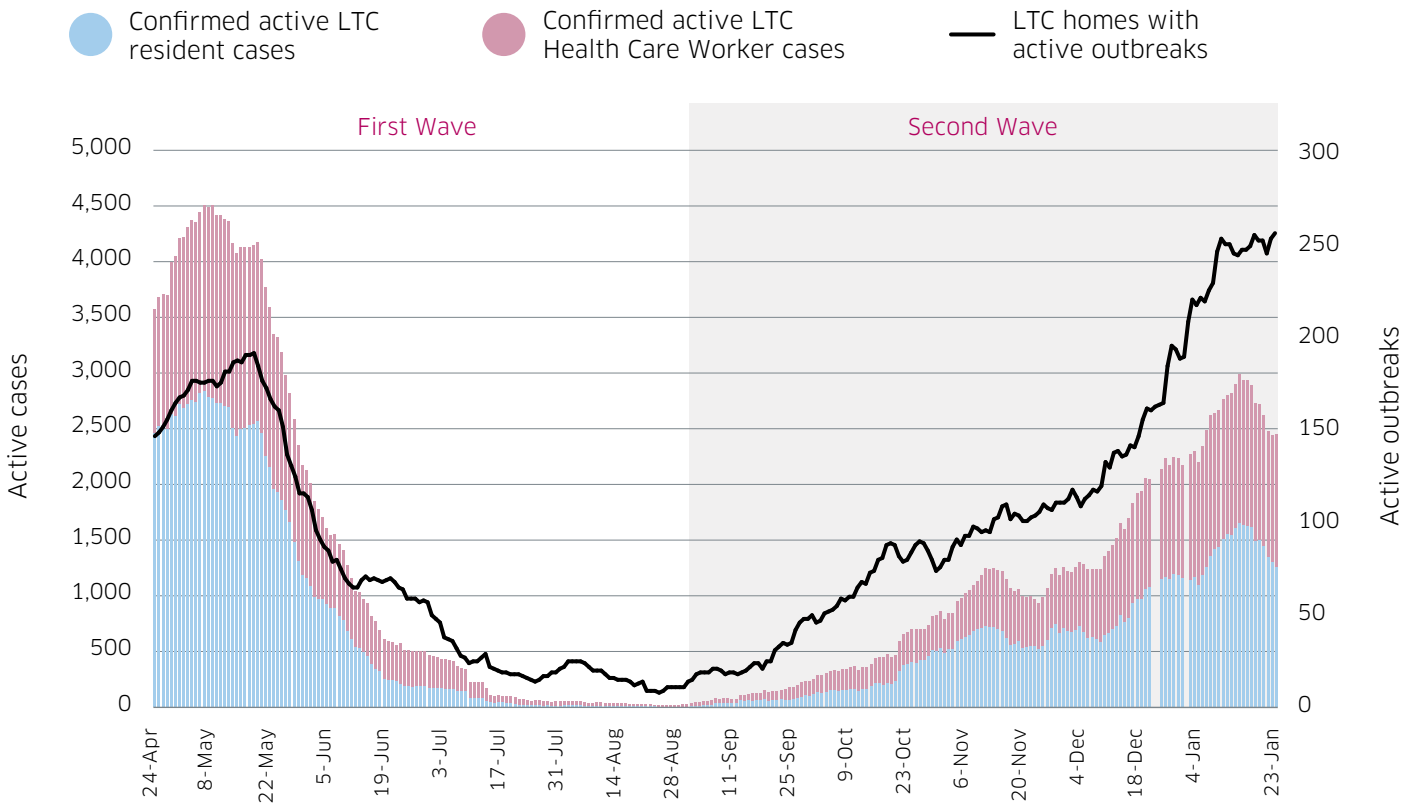


Figure 1 illustrates the number of active cases and outbreaks during the first and second wave in long-term care.

The Ontario Auditor General made similar observations on the province’s pandemic decision-making:

“We found that key lessons identified in the aftermath of the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 had not been implemented by the time COVID-19 hit Ontario, and were not followed during Ontario’s COVID-19 response.

For example, the SARS Commission’s final report identified the precautionary principle – taking preventative measures to protect the public’s health even in the absence of complete information and scientific certainty – as the most important lesson of SARS. Following this principle means taking decisive action early. This is not what we saw in our audit work; instead, we saw delays and conflicts and confusion in decision-making.”²⁹

This slow pace carried over to the issue of recognizing airborne transmission as a serious risk.

Despite a growing consensus on airborne transmission and repeated warnings from registered nurses, unions, engineers and other worker safety experts, Ontario has failed to implement related precautionary measures in a timely manner.

On November 5, 2020, the Public Health Agency of Canada (PHAC) acknowledged COVID-19’s airborne risks.

When Public Health Ontario failed to follow suit and update its guidelines, the Ontario Nurses’ Association sent a letter to the Chief Medical Officer of Health on November 26, 2020, “urgently requesting that Ontario’s directives and guidance be revised to recognize precautions for airborne transmission of COVID-19.”

When nothing happened, ONA sent an open letter to Premier Doug Ford on January 25, 2020:

“Nurses and health-care professionals expect urgent and decisive action – that you and the government immediately update your directives and guidance to mandate precautions for airborne transmission, including the use of N95 respirators for all nurses and health-care professionals who come into contact with any suspected or positive COVID-19 patients, residents or clients.”

This continuing lack of action has placed registered nurses in an impossible situation, and further tested their trust in public health leadership. They know that COVID-19 spreads through the air and that N95 respirators are essential protection against an airborne threat. Yet, months after the PHAC announcement, Ontario guidelines still say that surgical masks – designed to protect the surgical field and not the wearer against aerosol transmission – are sufficient protection.

“As a registered nurse, I am aware of personal protective equipment limitations, care and use,” said one nurse. *“I was a nurse during SARS.”*

Registered nurses with decades of experience observed that many health care workers in long-term care became infected with COVID-19 while following the province’s guidelines.

“We were told we were over-exaggerating the problem,” said one nurse. *“Our staff members who have a good education on infection control became ill.”*

A Human Tragedy

The experiences of registered nurses offer an important window into the price they, their colleagues, and residents have and continue to pay for Ontario’s failures.

Ten health care workers in long-term care have tragically died in long-term care as of January 23, 2021,³⁰ including Brian Beattie, a dedicated, well-loved 57-year-old registered nurse in London, Ontario, who considered residents his “other family.”

A few days before he contracted COVID-19, Brian, who had worked as a registered nurse for 23 years, texted about the toll it was taking on his facility and its staffing: *“hitting us hard here”* and about the number of shifts he had worked – *“so doing 12 hours, night 7.”*



Brian Beattie, RN, with his niece Amber.

As an experienced registered nurse, Brian was very cognizant of the need to take a precautionary approach and equip health care workers with N95s in long-term care. However, he was denied them. His employer, citing the province’s non-precautionary guidelines, refused to provide N95s. Not long before he was infected and died in May 2020, Brian texted a colleague stating: *“will not give N95. They say they are [sic] following ministry but I bring my own...”*

His niece issued a poignant statement on behalf of his family:

“He was dedicated to his work. He loved his job – we always knew that. However, since his passing, hearing all the stories from colleagues and those he cared for truly opens our eyes on how much he touched others’ lives. Thank you to all that have shared.”

Like in a “war country”

The experiences of many registered nurses were very traumatic.

“I was in a war country,” said one registered nurse in long-term care during COVID-19. *“I was bombed. This situation is worse than how I felt in the war.”*

This registered nurse, whose searing experience in a long-term facility battered by COVID-19 was more hellish than war, is not alone.

Many of her nursing colleagues in long-term care also reported levels of anguish, trauma, and grief more commonly found in conflict zones and natural disasters:

“I have never felt more helpless. There were too many residents dying and I couldn’t help them all.”

“COVID has a horrible smell. Despite the mask, you can smell the death.”

“We were abandoned.”

These kinds of experiences have been the norm for far too many registered nurses: Nearly half of registered nurses in long-term care surveyed by the Ontario Nurses’ Association reported suffering symptoms of post-traumatic stress as a result of COVID-19.

One survey respondent said:

“I feel utterly unsupported as a nurse. I feel disposable, replaceable. Nobody really cares about our safety.”

Registered Nurses and Long-Term Care

Registered nurses receive extensive education that provides them with the necessary skill and ability to provide care autonomously for clients in long-term care who have:

- Complex needs involving fluctuating health conditions that are not well controlled or managed; who require frequent monitoring and reassessment; and whose coping mechanisms and supports are unknown, not functioning, or not in place;
- Unpredictable outcomes and unpredictable changes in health conditions;
- Signs and symptoms subtle and difficult to detect; and
- A high risk of negative outcomes.³¹

Nurses’ responsibilities in long-term care go beyond overseeing and providing direct care for a vulnerable population:

“[The] RN is responsible for everything from organizing the emergency transfer of a resident to an acute care hospital, to coordinating the institutional response to a fire alarm, to dealing with an overflowing toilet. These additional responsibilities only add to the stress of an already high-pressure job.”³²

Registered nurses in long-term care are on-site 24 hours a day, seven days a week, supervising other staff, conducting assessments, and planning and performing a range of vital treatments, including skin and wound care, tube feeding, ostomy care and ventilation assistance.

It is the role of registered nurses to collaborate with other team members and intervene when a resident’s condition

deteriorates as it did so many times during the COVID-19 outbreaks in nursing homes across the province. They troubleshoot, receive direction from a physician who is often not in the building, deliver critical care and guide registered practical nurses, personal support workers, and other members of the health care team.

As one study noted:

“Outside of normal business hours (that is, nearly three-quarters of the time in the 24/7 world of long-term care), the person in charge of a long-term care home is an RN – and may be the only RN in the home on a shift.”³³

The decrepit state of many long-term care facilities has forced nurses to take on such tasks as fixing building problems and handling janitorial duties.

“Our nursing home is falling apart,” said one nurse. *“The fire alarms go off. Bed alarms don’t work. There are leaks in the building. It is the expectation that registered nurses respond to leaks. We are required to stop our medical work and now be housekeeping and maintenance. There are mice and ants in the building.”*

The everyday challenges of nursing in long-term care were exacerbated by COVID-19.

During the pandemic, registered nurses in long-term care were even forced to take on functions usually performed by funeral home staff who refused to enter nursing homes. This included placing the body of a deceased resident – usually someone the nurse had cared for and known – into a body bag and placing required identification on the body.

The following are poignant comments from the experiences of registered nurses forced to take on funeral staff duties:

“This was very hard on staff personally and emotionally. Working with, and caring for, these residents for as long as we do, then having to place them in the body bag is very emotionally draining.”

“We were all bagging bodies. Doctors, pharmacist, coroner, funeral home...[were] not coming into the home. Just the people who were there from day one. We are the only ones. We were abandoned.”

“It was horrible to have someone who cared for them as family to have to do that.”



We have never been this short-staffed. No RN on nights for months.

–ONA member, survey response

The Failure to Listen to Nurses' Clinical Judgment

Despite registered nurses' unique role in long-term care – and their years of clinical experience working with geriatric residents that extended into the COVID-19 pandemic – government and long-term care facilities repeatedly dismissed their valuable expertise.

In this, COVID-19 has revealed the continuation of an historical failure in medicine: The failure to respect, acknowledge, and learn from the clinical judgment and experience of nurses.

Because of their clinical experience in long-term care, registered nurses likely have Ontario's most extensive first-hand empirical experience with COVID-19 among senior health care professionals.

Yet, as documented throughout this report, their warnings and insights have been ignored and disregarded.

That this occurred during COVID-19, as it had during SARS, will not come as a surprise to registered nurses.

This has a lengthy historical antecedent highlighted by Justice Murray Sinclair in 2000 in his inquiry into the deaths of 12 infants at a Winnipeg Hospital. He found that concerns raised by nurses were disregarded – with fatal consequences.

He wrote:

“Historically, the role of nurses has been subordinate to that of doctors in our health-care system. While they are no long[er] explicitly told to see and be silent, it is clear that legitimate warnings and concerns raised by nurses were not always treated with the same respect or seriousness as those raised by doctors. There are many reasons for this, but the attempted silencing of members of the nursing profession, and the failure to accept the legitimacy of the concerns, meant that serious problems in the paediatric cardiac surgery programme were not recognized or addressed in a timely manner. As a result, patient care was compromised.”³⁴

Fast forward to North York General Hospital during SARS. Something similar occurred during the second phase of the 2003 outbreak, just after Ontario had declared victory over the new pathogen and lifted precautions on May 13, 2003.³⁵ Four days later the provincial emergency ended. There was widespread euphoria in Toronto – not unlike the feelings of relief many Ontarians felt after COVID-19 lockdowns began to ease in the summer of 2020.

However, at North York General, the mood among registered nurses was decidedly less euphoric. They wanted to keep wearing N95 respirators but were discouraged from doing so. They didn't think SARS had gone away.

One nurse told the SARS Commission:

“We heard a lot of how it appeared to see us wearing masks, how it frightened them off... It just seemed like they were more concerned with what we looked like to the community, how we appeared...”

It was ridiculous that they cared more about what we looked like to the general public than they cared about how we could have been exposed.”

Nurses at North York General saw many signs that SARS was still there and appeared to be spreading. Their growing concerns culminated in a May 20, 2003 meeting with hospital officials and infectious disease experts who told the registered nurses they were wrong.

The meeting, as Justice Campbell observed, “seemed focused on convincing them [the nurses] that they were wrong, that SARS was gone.”³⁶

One nurse who attended the meeting said nurses tried to convince the hospital's infection control expert that a case involving one family was SARS:

“The nurses were telling her this is SARS; if it smells like SARS and it looks like SARS and acts like SARS, it's SARS. [The infection control expert] said no, it was community acquired pneumonia and they should stop it. You know: Stop talking about it.”³⁷

Justice Campbell wrote:

“It turns out that the nurses were exactly right and the hospital’s assurances were exactly wrong.”

This outbreak resulted in 118 new SARS cases and 17 deaths, including registered nurse Nelia Laroza.

The fact that nurses had not been listened to had, as Justice Campbell noted,

“...a terrible impact on the morale of health care workers. Many lost faith in the system and the ability of their employers to protect them.”

Justice Campbell contrasted the failure to listen to health care workers to the situation at Vancouver General where listening to workers’ concerns was an integral component of Vancouver General’s robust safety culture.

An infection control expert at Vancouver General told the Commission:

“And we get the feedback from the workers...I mean you know we are not working in isolation here. You have to respect the opinions of the health care workers. And they have to have confidence in the system and in what you are doing for them. If they don’t have confidence, then you won’t have people coming to work...”

The failure to listen to the clinical judgment of nurses has continued during COVID-19 – to the detriment of residents, health care workers, and the public – resulting in the failure to follow crucial infection control protocols, and health and safety measures to keep everyone safe.

One nurse said:

“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 [there were] too many residents with too much proximity, they shouldn’t be there.”

Another nurse said:

“They insisted they would follow guidelines – but guidelines were insufficient and there was not enough personal protective equipment available. They were giving us one surgical mask for four days at the beginning, and insisted we would not need N95 masks because guidelines were for droplet precautions and we

had no aerosolizing procedures. I insisted that if we were to have presumed or positive cases, that we would need better protection such as N95s and goggles. They insisted that surgical masks would be sufficient.”

A third nurse added:

“There were COVID-19 positive residents dying. No one really knew if it was droplet or airborne. I raised concerns. I spoke with co-workers and said we need N95s... When I spoke with the [infection control] lead, she said she spoke with head office, and N95s were only allowed for [aerosol-generating procedures]...”

The only time N95s were given is after [someone] died and then the boxes [of N95s] were out, no problem.”

Registered nurses were placed in the disheartening position of being lectured by less experienced hospital-based infection control practitioners who claimed COVID-19 did not spread through the air, and that surgical masks were sufficient.

A glaring example occurred on October 16, 2020, when a hospital infection control practitioner at one facility admonished registered nurses for being concerned about airborne transmission and for requesting N95 respirators.

In summarizing a staff meeting, the practitioner sent a condescending email stating:

“We did have a meeting with the first floor team today (we will do the same with the 2nd floor tomorrow) to review required precautions for routine care of COVID-19 residents, which as you are aware, is droplet-contact precautions (ie surgical/ procedure mask, gown, gloves and face shield)...

We talked about some of the fears that staff have related to COVID that makes them believe that they require an N95 mask for routine care and we discussed the evidence, and current public health guidance that is included in Ministry of Health guidance documents and directives. I clearly explained that the evidence remains that this is an illness that is predominantly transmitted through droplets within 6 feet of a covid+ person.”

These encounters were repeated over and over during COVID-19 with poorly informed infection control specialists providing guidance that, while consistent with provincial guidelines, was in fact outdated, ill-informed, and possibly dangerous.

Over and over, month after month, nurses and other health care workers were given advice that was contrary to the precautionary principle; the growing scientific evidence of airborne transmission; and the experiences of China, Taiwan, Hong Kong and South Korea that had managed to keep their health care workers safe through the use of airborne precautions.

Consider:

- One nurse said she was told that masks don't help: *"Practice good hand hygiene...should be enough."*
- A second nurse recounted how when an outbreak was declared at her facility, she was denied a mask and was told not to wear a mask even if she supplied her own: *"I was told I would be escorted off the property if I wore a mask at work."*
- Another nurse recalled suggesting *"to management that we should start screening and offer masks to staff. I was denied and was told 'we are not going to be crazy' and 'we don't have enough supplies.' I asked my co-workers to put a mask on when on duty with our own masks. Management denied."*

A Crisis of Science

What held Ontario back? Why didn't Ontario perform as well as its SARS peers or South Korea?

The evidence points to a major difference between Ontario, on the one hand, and China, Hong Kong, Taiwan and South Korea, on the other. They took a precautionary approach, disavowed the guidance of the World Health Organization (WHO), and, in the process, eschewed a central orthodoxy of infection control: The outdated large droplet model of disease transmission.

Despite repeated urgings from registered nurses, unions and worker safety experts, Ontario did the exact opposite, clinging to the large droplet model, even as its scientific foundations were crumbling. The province is paying a heavy price in death and disease.

In fact, Ontario has some of the world's most vocal, and influential, proponents of the large droplet theory.

When 239 scientists wrote the WHO in June 2020, citing the precautionary principle, and urging it to acknowledge COVID-19's airborne transmission characteristics, a

group of traditional infectious disease experts published a critique defending the large droplet model. About half the signatories were Canadians, including a strong contingent from Ontario.³⁸

The large droplet model holds that COVID-19,

"...is spread mainly by contaminated surfaces and by droplets bigger than aerosols that are generated by coughing, sneezing, and talking. These are thought to travel relatively short distances and drop quickly from the air."³⁹

Hence, Ontario's persistent focus on hand washing, surface cleaning and measures like plexiglass barriers.

But, as *Nature* magazine has noted,

"This type of guidance has hampered efforts that could prevent airborne transmission, such as measures that improve ventilation of indoor spaces..."⁴⁰

The large droplet model is based on 1930s research when scientific instruments were too primitive to examine tinier airborne particles. This model, which divides respiratory exhalations into small and large droplets is "by modern standards...overly simplified."⁴¹

Since then, science's ability to measure, track and understand respiratory droplets has progressed in leaps and bounds, especially in the years since SARS, and during COVID-19.

New instruments and techniques have allowed scientists to demonstrate that when people sneeze, cough and speak, they emit "turbulent gas clouds" of various sized respiratory particles, including the large ones first identified in the 1930s.⁴²

Leading researchers have dismissed the large droplet model as being comprised of "myths," "dogmas," and "mythological beliefs that obscure current thinking."⁴³

To understand why, think of aerosol spread like being in a room with a smoker. Aerosol expert Dr. Linsey Marr explains:

"If you're near a smoker outside, you may not notice the smell, especially if you're not standing too close. But if you're indoors, you could definitely detect it, even if you're across the room, depending on how far away you are and how well-ventilated or filtered the air is."⁴⁴

Dr. Julian Tang, a British virologist, uses a similar everyday analogy:

“If you can smell what I had for lunch, you’re getting my air, and you may be getting virus particles as well.”⁴⁵

By ignoring the possibility of airborne transmission, Ontario has relied on the wrong approach.

Dr. David Fisman, a professor at the University of Toronto, “...likened the aerosol transmission of the coronavirus to cigarette smoke: installing plexiglass barriers does not prevent it from drifting to the other side... You can’t combat something if you get the model wrong.”⁴⁶

“Identifying the transmission route of an infectious disease, including COVID-19, is not an esoteric scientific question,” adds Rachel Jones of the University of Utah’s Medical School, “because it is the transmission route that drives the infection prevention and control strategies.”⁴⁷

She goes on to explain:

“Consistent with initial determinations that COVID-19 is transmitted through the droplet and contact routes, the primary public health interventions were physical barriers, physical distancing, face shields, and hand hygiene. Later, cloth masks were added. These strategies have little impact on the movement of small droplets that can be inhaled, though new research suggests that cloth masks can prevent the emission and inhalation of small droplets. The performance of cloth masks (and surgical or medical masks), however, is meaningfully inferior to that of respirators, including N95 or FFP2 filtering face piece respirators.”⁴⁸

The history of medicine and science is replete with many examples of old orthodoxies clashing with new discoveries and new models. Usually, these battles are fought out of the public spotlight, in academia and in medical journals. But sometimes these battles are very public.

A case in point occurred at the birth of modern-day public health in Victorian London when Dr. John Snow argued (rightly on the basis of modern science⁴⁹) that cholera was spread by contaminated water, not contaminated air, as the orthodoxy of the day held. In an echo of how Ontario has too often downplayed evidence of airborne transmission, health authorities of the day dismissed Snow’s evidence as “suggestions” and “belief,” concluding: “We see no reason to adopt this belief.”⁵⁰

The tragedy of COVID-19 in Ontario is that the province found itself on the wrong side of history, on the wrong side of a pivotal scientific debate, at precisely the worst possible time.

This came to a head when Ontario downgraded precautions on March 10, dismissed the precautionary principle, and said, with the certainty with which London officials dismissed Dr. John Snow’s research, that COVID-19 did not spread through the air.

There are now extensive efforts to move medicine and science past the now outdated large droplet model. Unfortunately, this is coming too late for the victims of COVID-19.

In a call to arms increasingly echoed by medical experts around the world, Dr. Jones stated:

“While updating the disease transmission paradigm during a global pandemic may seem overwhelming, we owe it to the workers who sustain the functions of daily living and are at risk of COVID-19 – and a myriad of endemic and future pandemic diseases – to use the best, current scientific evidence to guide prevention strategies.”⁵¹

History may well look back at Ontario’s response to COVID-19 and classify it as another example of scientific missteps – alongside the sceptics of Dr. John Snow’s day.

Conclusion

This report will consider evidence rooted in the testimonials of registered nurses who directly experienced the grim realities of the COVID-19 pandemic and bore witness to the suffering of residents.



Our nursing home is falling apart. The fire alarms go off, bed alarms don’t work, there are leaks in the building. –ONA member, interview with ONA counsel

To answer these questions, I begin with an examination of key lessons drawn from the past and the present.

In Chapter 2, The Failure to Learn from SARS: “I am angry all the time,” I will review the key lesson of SARS: the precautionary principle. In reviewing the evidence through the lens of the SARS experience, I conclude that Ontario has not adopted the precautionary principle.

In Chapter 3, The Failure to Prepare, I will examine the state of pandemic preparedness in Ontario leading up to the peak of the first wave.

In Chapter 4, The Nexus of the Disaster, I will analyze the fatal decision by the Ontario government in March 2020 to downgrade COVID-19 precautions to contact and droplet and the implications this decision had for registered nurses.

In Chapter 5, Long-Term Care, A Troubled Past, I examine historical issues associated with the long-term care sector by highlighting key reports and recommendations that went largely ignored.

I then examine the events of the last year in nursing homes across Ontario through several sources of evidence:

Chapter 6, Survey of Registered Nurses in Long-Term Care, captures the observations and experiences of registered nurses during the first wave.

Chapter 7, Case Studies – Anson Place and Madonna Care, details two case studies of nursing homes that demonstrate the systemic issues in the long-term care sector.

Chapter 8, Filling the Vacuum of Government Inaction, explores the legal proceedings brought by the Ontario Nurses’ Association on behalf of registered nurses and residents that were precipitated by urgent safety issues and ongoing challenges, which continued into the second wave.

Chapter 9, Recommendations from the Front Lines, then considers the solutions that are needed based on an examination of all the evidence.

Chapter 10, Conclusion, ends with some final remarks and reflections.

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Chapter 2

The Failure to Learn From SARS: “I am angry all the time”

2

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Introduction:

“Mommy, are you going to die?, asked the nine-year-old daughter of a nurse.”⁵²

“I was torn between staying and quitting because my husband was scared.”

“Nobody listens to nurses.”

“Job not worth the risk of dying.”

These poignant quotes from the SARS Commission’s Final Report⁵³ reflected the experiences of tens of thousands of registered nurses during the 2003 outbreak of Severe Acute Respiratory Syndrome, or SARS, the 21st century’s “first severe and readily transmissible new disease.”⁵⁴

During COVID-19, Ontario registered nurses in long-term care are voicing similar sentiments:

“I felt like a lamb being led to slaughter.”

“I regret my choice of career.”

“I am angry all the time.”

“Employer was not listening to registered staff.”

“I am so scared to die.”

That the experiences of registered nurses during SARS and in long-term care during COVID-19 are so similar is troubling evidence of Ontario’s failure to heed the lessons of SARS, both in pandemic preparedness and in efforts to contain the first and second waves of COVID-19.

The burden of SARS fell heaviest on Ontario health care workers, who comprised 44 per cent of all SARS cases in Canada, one of the world’s highest rates of infection among medical workers.⁵⁵

Two Ontario registered nurses – Nelia Laroza, 52, and Tecla Lin, 58 – and physician Nestor Yanga, 55, died. All three were highly respected:

- Of Nelia Laroza, one colleague said: “She was as good as it gets for anyone. She was just your good, basic, decent person.”
- Of Tecla Lin, one doctor who knew her well recalled: “When Tecla died, it was the worst.”
- Of Nestor Yanga, one colleague said: “He would make you feel that you were special and that you were the most important person.”⁵⁶

While SARS’s destruction pales in comparison to COVID-19’s devastation, it nevertheless had a significant negative impact on Ontario, its people, its economy and its reputation in the world.

In a taste of what COVID-19 would bring, air travel during SARS was curtailed, and Ontario was stung by a World Health Organization travel advisory. There was widespread fear of travelling to Toronto.⁵⁷

For a time, Ontario was seen as a pariah. As Justice Archie Campbell noted in his final report:

“SARS was a tragedy... It caused untold suffering to its victims and their families, forced thousands into quarantine, brought the health system in the Greater Toronto Area and other parts of the province to its knees and seriously impacted health systems in other parts of the country.”⁵⁸

What makes the SARS experience so important – and why ignoring its lessons is so troubling – is that it constituted a “dress rehearsal”⁵⁹ for a full-blown pandemic, offering vital lessons in health worker safety and pandemic preparedness.

The philosopher George Santayana once said: “Those who cannot remember the past are condemned to repeat it.”

Sadly, Ontario is a poster child for the perils ignoring that wise advice. History is tragically repeating itself in long-term care in Ontario.



The home couldn’t even staff before the outbreak. Staffing can only be described as skeletal at the best of times. –ONA member, interview with ONA counsel

SARS and the Precautionary Principle

Let's begin by examining how and why the precautionary principle became a cornerstone of the SARS Commission.

Before SARS, it arguably had its highest profile in environmental law.⁶⁰

Justice Campbell's innovation was to apply it to public health, occupational health and safety, and pandemic preparedness and containment.

In this, Justice Campbell was influenced by Justice Horace Krever, who was appointed in 1993 by the Canadian government to head the Royal Commission of Inquiry on the Blood System in Canada.

The Krever Commission, as it became known, investigated how and why tainted blood and blood products infected thousands of Canadians with the AIDS virus and Hepatitis C.⁶¹

While many factors contributed to this tragedy, Justice Krever focused on the absence of a precautionary approach by the administrators and regulators of Canada's blood system:

"The slowness in taking appropriate measures to prevent the contamination of the blood supply was in large measure the result of the rejection, or at least the non-acceptance, of an important tenet in the philosophy of public health: action to reduce risk should not await scientific certainty. When there was reasonable evidence that serious infectious diseases could be transmitted by blood, the principal actors in the blood supply system in Canada refrained from taking essential preventive measures until causation has been proved with scientific certainty. The result was a national public health disaster."⁶²

Fast forward to SARS. Some of the best supporting evidence for the precautionary principle came right at the start of outbreak. The country's first two SARS patients presented separately to Scarborough Grace Hospital in Toronto and Vancouver General Hospital, on the same day (March 7, 2003), within three hours of each other.⁶³

The Vancouver index patient was isolated within five minutes of being admitted. Ten minutes later, he was placed on "full respiratory precautions." Health care workers wore airborne precautions, including N95 respirators.

This was consistent with the policy of Vancouver General. When dealing with an undiagnosed respiratory illness, health care workers applied a precautionary approach.

One Vancouver General expert told the Commission:

"We always start with the highest level of precaution...we don't use droplet precautions in our hospital, never have, because we've always believed that droplets have been aerosolized so we only have one category that's airborne. And you always start with the highest precautions and then as the clinical situation becomes clearer, you step back on your precautions."⁶⁴

In contrast, the index patient at Scarborough Grace was not isolated for nearly 21 hours and spent 76 per cent of that time in a crowded emergency ward. Health care workers used contact and droplet precautions. In those 21 hours, SARS spread dramatically at Scarborough Grace, leading to a total of 128 SARS cases.

Forty-seven of the cases, or 36.7 per cent, were hospital staff who had been using the droplet and contact precautions of a surgical mask. Patients and visitors accounted for 36 of the cases, or 28.2 per cent, demonstrating the strong correlation between health worker safety and outbreak containment.⁶⁵

British Columbia had just four probable cases and only one case of local transmission involving a nurse. No other nurse, physician, respiratory therapist, cleaner or other B.C. health worker caught the disease.

While some have suggested that good fortune was the reason for British Columbia's better outcome, Justice Campbell found that the province had "made its own luck" because of the precautionary approach taken by Vancouver General Hospital.

In the SARS Commission's final report, Justice Campbell wrote that the precautionary approach,

"...was in use at Vancouver General Hospital when it received B.C.'s first SARS case on March 7, 2003, the same day Ontario's index case presented at the Scarborough Grace Hospital [in Toronto]. When dealing with an undiagnosed respiratory illness, health workers at Vancouver General automatically go to the highest level of precautions and then scale down as the situation is clarified. While the circumstances at Vancouver General and the Grace Hospital were different, it is not surprising that SARS was contained so effectively at an institution so steeped in the precautionary principle."⁶⁶

Another important piece of evidence in support of precaution was the fact that research confirming SARS's ability to spread through the air did not emerge until about a year after the outbreak.⁶⁷

Justice Campbell said this validated the precautionary approach:

“Part of the heated debate during the SARS outbreak was over whether N95 respirators were really necessary. Those who argued against the N95, which protects against airborne transmission, believed SARS was spread mostly by large droplets. As a result, they said, an N95 was unnecessary except in certain circumstances and a surgical mask was sufficient in most instances. They made this argument even though knowledge about SARS and about airborne transmission was still evolving. That more and more studies have since been published indicating the possibility under certain circumstances of airborne transmission, not just of SARS but of influenza, suggests the wisdom and prudence of taking a precautionary approach in the absence of scientific certainty.”⁶⁸

Since SARS, Justice Campbell's finding on the precautionary principle has influenced the thinking on employers' duty of care obligation – the obligation to take “every precaution reasonable in the circumstances for the protection of a worker” – under the *Occupational Health and Safety Act (OHSA)*.

Lawyers at Osler's, the Toronto law firm, noted in a guide for employers on SARS lessons for COVID-19 (bold added):

“Following the SARS outbreak, the SARS Commission's Final Report established that hospitals are expected to exercise an elevated duty of care in accordance with the “precautionary principle,” meaning that scientific proof of a particular risk (e.g., airborne transmission of SARS and, therefore, the need for the N-95 mask) is not required before taking precautionary measures against that potential risk. In our view, **this sets out a higher standard for the duty of care and expands the scope of the meaning “every precaution reasonable” as required under the [Occupational Health and Safety Act] OHSA.** As Honourable Mr. Justice Archie Campbell stated in the SARS Commission's Final Report, “[t]he point is not science, but safety... We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.”⁶⁹

This raised the bar for employer action against new respiratory illnesses like SARs.

Failure to Follow the Precautionary Approach during COVID-19

In an echo of SARS, there has been a sharp division during COVID-19 between those advocating for a precautionary approach, mainly unions, registered nurses and worker safety experts, and those on the other side, primarily public health agencies and their supporters in infectious disease, who say such an approach is not necessary.

This tension was on display in the Ontario response to a July 2020 letter to the World Health Organization (WHO) signed by 239 experts from 32 countries, including 40 from Canada. It called on the WHO to revisit its deep-seated resistance to growing evidence of airborne transmission.

Suggesting that it is precisely during a time of scientific uncertainty that the precautionary principle should be invoked, the authors noted:

“It is understood that there is not as yet universal acceptance of airborne transmission of SARS-CoV-2; but in our collective assessment there is more than enough supporting evidence so that the precautionary principle should apply. In order to control the pandemic, pending the availability of a vaccine, all routes of transmission must be interrupted.”⁷⁰

The letter has been widely dismissed by Ontario public health and infection control experts, who judged it not on its precautionary message but on whether it proved airborne transmission.

One Toronto infectious disease expert dismissed the letter, saying:

“We're just rehashing the same arguments that we've heard throughout February, March, April, up until now. I'm not sure what all the fuss is about.”⁷¹

Until the evidence became overwhelming, the public health community appeared unwilling to accept the possibility of airborne transmission unless there was the kind of proof typically associated with randomized control trials.⁷²



As a nurse, the first defence is precautionary measures. Don't wait until everyone is sick. –ONA member, interview with ONA counsel

Dr. Trish Greenhalgh, a signatory of the WHO letter, notes that while randomized trials make sense for drug and vaccine safety, this standard is not appropriate for gauging public health measures:

“Randomised trials were developed to test drugs. As we know from thalidomide, new drugs can cause terrible harm. Scientists arguing for caution in the masking debate are almost all medically trained and view the principle “do no harm” (by which they mean, never give a new drug to any patient before it’s been tested in a randomised trial) as overriding.”⁷³

Experts have argued that randomized trials for worker safety measures are neither ethical, nor practical.

Dr. Lidia Morawska, a leading aerosol researcher in Australia and co-author of the WHO letter, has noted:

“There [is] no way to humanly conduct the kind of experiment that would prove unequivocally that SARS-CoV-2 could infect people through respiratory aerosols. It would involve putting healthy people in one room and COVID-19 patients in another, with only an air vent between them. And you’d have to do it in large enough numbers to reach statistical conclusions. No ethical body would sign off on such a study.”⁷⁴

Moreover, the same high evidentiary bar has not been applied to many public health measures, say critics like Dr. Greenhalgh:

“There are no randomised controlled trials in community settings, for example, of hand washing, social distancing, closing schools, quarantining, closing borders or contact tracing.”⁷⁵

Registered Nurses and the Precautionary Principle

Based on their training, clinical experience and expertise, registered nurses are grounded in the precautionary principle, and its importance in controlling a new pathogen. They were on the right side of history during SARS and are on the right side of history some 17 years later.

“As a nurse working in long-term care,” said one registered nurse, *“the first defence is the precautionary measure. Don’t wait until everyone is sick.”*

Ontario has done the exact opposite, alarming registered nurses, other health care workers, unions and worker safety experts.

As Vicki McKenna, President of the Ontario Nurses’ Association (ONA), remarked:

“I couldn’t believe that I was having the same discussions that I had years ago as a practising nurse when SARS happened, when the precautions were late coming then as well, and there was resistance to higher levels of protection.”⁷⁶

Some infectious disease experts even made highly charged public comments against those who called for the precautionary principle and who warned it was not safe to rule out airborne transmission.

In a letter to the *Toronto Star* in May 2020, punctuated by claims that those who argued for the precautionary principle added “fuel to fire,” some of Ontario’s top infectious disease specialists stated:

“COVID-19 is almost exclusively spread via droplets... If COVID-19 were an airborne infection, physical distancing rules would not be effective and we would see large and widespread outbreaks in places adhering to droplet prevention, including hospitals. We have not...

...misinformation has already led to confrontation. We understand why some groups want the right to wear N95 masks universally. Those challenges are underpinned by the belief this disease is airborne, and that wearing N95 masks will reduce health-care worker risk, when the evidence and the science say otherwise.”⁷⁷

History has proven them wrong. Ontario has reported a total of 396 outbreaks in hospitals as of February 17, 2021.⁷⁸

As will be detailed below, the basis for that scientific certainty was in doubt at the time of the *Toronto Star* letter, and indeed from the start of the pandemic.

That there is now a consensus that COVID-19 spreads through the air validates the precautionary approach advocated all along by registered nurses, other health care workers, unions, and occupational health and safety experts.

Aerosol transmission of COVID-19 is now widely recognized by the WHO and the Public Health Agency of Canada (PHAC).

The Centers for Disease Control and Prevention has gone so far as to suggest that it is, in fact, the main route of transmission (bold added):

“It spreads through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes. These particles can be inhaled into the nose, mouth, airways, and lungs and cause infection. **This is thought to be the main way the virus spreads.**”⁷⁹

“The precautionary principle was fully ignored,” said one nurse. *“It makes me so angry.”*

COVID-19: An Unknown

COVID-19 has consistently surprised the medical community:

“[T]he virus has been implicated in skin lesions, the loss of taste and smell, heart problems, strokes, brain damage, and other side effects, some of which can be traced back to the virus’s ability to infect the endothelial cells that line blood-vessel walls. The virus also appears to trigger an out-of-control immune reaction, known as a cytokine storm, in some patients.”⁸⁰

Perhaps the most unexpected characteristic of COVID-19 – one that offers compelling evidence supporting the precautionary principle – is the large number of asymptomatic cases.

These are people who get infected but do not show symptoms or feel sufficiently unwell to see a doctor. Some may be described as subclinical⁸¹ or pre-symptomatic,⁸² who do not appear to be ill, but eventually become visibly ill. And there are those who

are truly asymptomatic and appear healthy throughout the course of their infection.⁸³

Until COVID-19, the evidence suggested that asymptomatic transmission was generally a “rare event,” and that epidemics historically were not driven by that kind of spread.⁸⁴

Now, however, as many as half of COVID-19 cases may fall into this category, according to Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases in the United States.⁸⁵

Ontario was not prompt in acting on the knowledge that those without symptoms could spread the virus. As late as June 2020, Ontario allowed farm workers who were positive for COVID-19, but not showing symptoms, to work together in the fields.⁸⁶

One infectious disease expert said:

“...having people who have recently tested positive for COVID-19, allowing them to work is, of course, generally speaking a bad idea.”⁸⁷

Ontario has not done all that it could have – and all that it should have – to protect health care workers and residents in long-term care.

“Droplet precautions were insufficient with COVID-19 patients,” said one registered nurse. *“The precautionary principle was disregarded completely. Employee and resident safety was disregarded and [it is] disgraceful.”*

Ontario Fails to Catch up to the Science

Despite the courage and dedication of registered nurses and other health care workers, by September 2020, the evidence suggested that the virus was spreading dangerously in long-term care – eventually the virus would spread with an intensity matching, and in some cases exceeding, the devastation of the first wave.

Figure 2 – Cumulative Case Count of COVID-19 in Long-Term Care

The following figure shows the upper ward curves of reported COVID-19 infection and death rates in long-term care during the first and second waves.

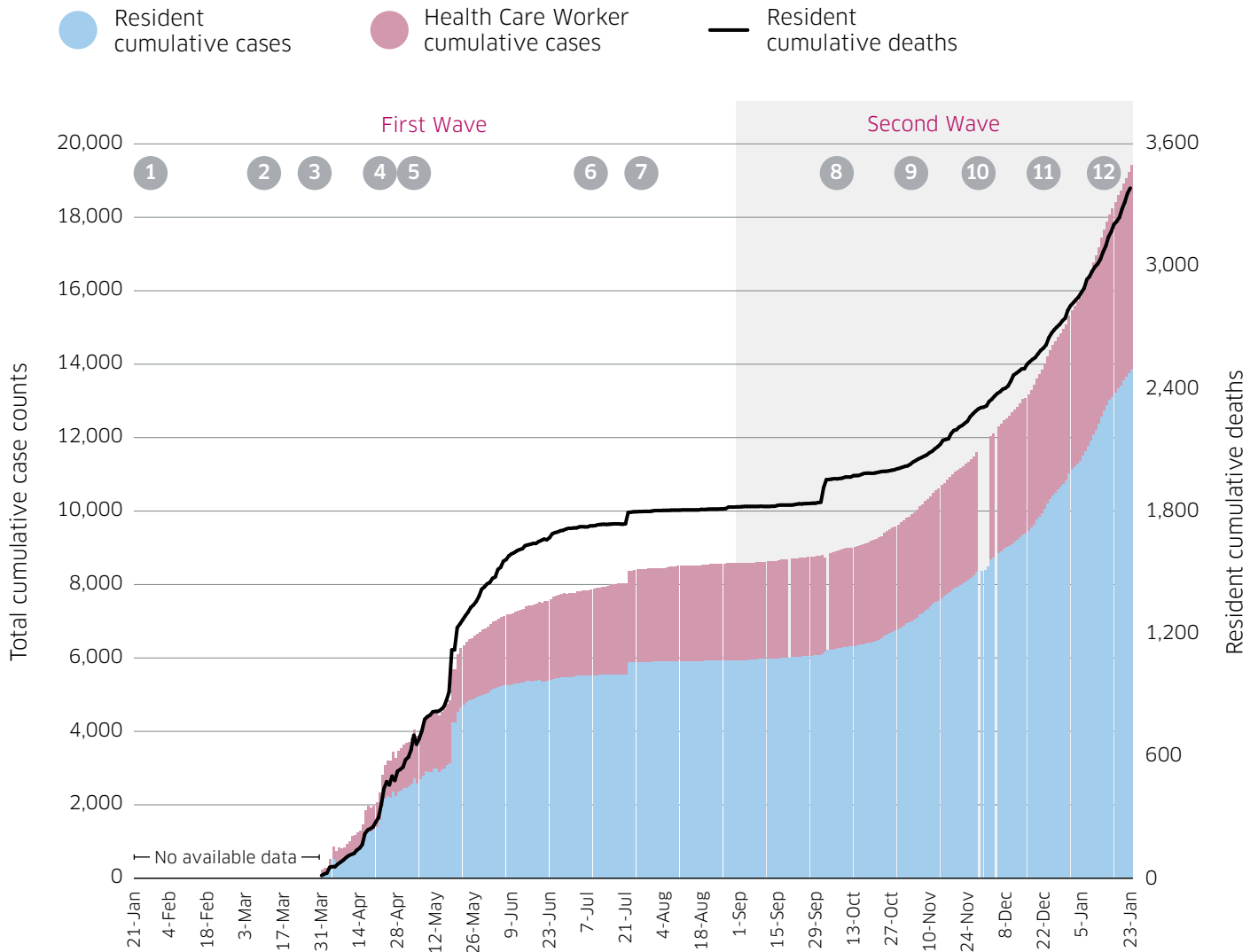
It also shows the government’s failure to take a precautionary principle by dropping airborne precautions from March 12, 2020 and throughout the pandemic, despite warnings from ONA and mounting evidence of aerosol transmission.

Figure 2 – Cumulative Case Count of COVID-19 in Long-Term Care

COVID-19 Timeline

COVID-19 cumulative reported infections and deaths in long-term care

March 31, 2020 – January 23, 2021



- | | | |
|--|---|---|
| 1. January 28, 2020: ONA warns Health Minister to follow precautionary principle and maintain airborne precautions | 5. May 4: ONA obtains Stout Award setting out requirements for more than 200 nursing homes | 9. November 3: The Public Health Agency of Canada recognizes aerosol transmission |
| 2. March 12: Ontario dismisses precautionary principle and drops airborne precautions | 6. July 9: The World Health Organization acknowledges that COVID-19 may linger in the air | 10. November 26: ONA sends letter to Dr. Williams urging him to update guidance |
| 3. March 30: Premier Ford: “Iron ring” to protect seniors | 7. July 24: Ontario state of emergency ends | 11. December 22: ONA sends letter to LTC Commission to issue interim recommendation |
| 4. April 22: Justice Morgan sides with ONA, issues orders against four long-term care homes | 8. October 5: The Centers for Disease Control and Prevention recognizes airborne transmission | 12. January 12, 2021: Ontario declares second state of emergency |

Even after PHAC reluctantly acknowledged the role of aerosol transmission in the spread of COVID-19, Ontario inexplicably did precious little to update its policies and procedures to put in place measures to control aerosol spread in long-term care, hospitals, schools, and other places of work.

As of the middle of January 2021, there was still no action by the province, displaying a lack of urgency that has characterized its response on a wide range of COVID-19 containment measures, including the rollout of vaccines.

Part of the problem, noted one infectious disease specialist, is that “some very well-established voices on the Canadian infection control scene...are quite adamant that this disease can’t possibly be transmitted via aerosols.”⁸⁸

This reluctance has unnecessarily worsened the troubling levels of death and disease among registered nurses, health care workers, and residents in long-term care, and in the province at large.

As the Ontario Society of Professional Engineers (OSPE), which has long advocated a precautionary approach and greater attention to airborne transmission, declared in a January 2021 statement, it is time for Ontario to focus on containing airborne transmission:

“It has been roughly 10 months since our first COVID-19 lockdown in Ontario, and case numbers are worse than ever. Social distancing, restrictions on businesses and more lockdown orders have been put in place, but during these winter months they do not seem to be helping. Many are feeling hopeless and are wondering ‘what more can be done to combat the spread of COVID-19?’ The Ontario government’s only response has been to close businesses, schools and other sites that are transmitting the virus. Are there other solutions to augment this?”

OSPE and its engineers believe there is a key piece to our defence against this virus that has not been properly addressed by the Ontario government – the need for proper ventilation and air filtration to stop the spread of the virus via infected aerosol particles in the air.”⁸⁹

Nurses also saw first-hand that the measures recommended by the province were inadequate.

“Staff used surgical masks religiously,” said one registered nurse, *“but most of them ended up testing positive.”*

“We didn’t have the damn tools,” added another registered nurse in long-term care. *“They wouldn’t give them to us. Everything was reactive.”*

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Chapter 3

The Failure to Prepare

3

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Introduction:

Shortages of N95 respirators were a feature of SARS, as they are during COVID-19.

Because Canada did not have any domestic production supply of N95 respirators during SARS (and still did not have at the start of COVID-19), Ontario scrambled to buy as many as it could.

One SARS response leader told the SARS Commission: “The decision was made to buy every N95 in North America. We bought out the market by the weekend.”⁹⁰

Despite these efforts, N95 shortages persisted in 2003.

An article in *The Lancet* medical journal written shortly after SARS noted:

“With 211 hospitals in Ontario alone requiring these supplies, Canadian suppliers rapidly ran out of stock. There was not pre-existing supply stockpile, and our mask suppliers were obtained from foreign manufacturers.”⁹¹

Ontario was fortunate because, unlike now, SARS did not affect the United States and thus American N95 supplies were not needed for their domestic use.

The Lancet article observed there were other international demands:

“Because SARS was a worldwide threat, there was great difficulty in acquiring masks for other countries, since foreign governments understandably wanted to keep such supplies for their own citizens.”⁹²

Recognizing these supply chain issues, Justice Campbell highlighted the importance of sufficient supplies of protective equipment:

“SARS not only underlined the importance of having an effective emergency management structure, it also emphasized the need to have sufficient quantities of medical supplies, secure supply chains and the means to distribute the supplies.”⁹³

To address this issue, Justice Campbell recommended:

“Measures resulting from advance planning require resources of people and equipment. Examples are surge capacity for human resources and medical equipment such as N95 respirators, gloves, gowns, visors and other protective equipment, and a secure source of supply and an effective logistical system to distribute them.”⁹⁴

A Commitment to Preparedness

In the months following SARS, the Ontario government began building up stockpiles of personal protective equipment.⁹⁵

This was detailed in the SARS Commission's First Interim Report released in April 2004:

“In order to address the serious problem of the lack of a sufficient supply of personal protective equipment for health care workers, patients and others that arose at the outbreak of SARS I, the Ministry has begun to stockpile and secure its supplies. The Ministry reported that a two-month stockpile of personal protective equipment, including masks, gloves, gowns, eye protection and other clinical supplies, for a community the size of Toronto is available and could be distributed quickly through a central distribution system.”⁹⁶

Three years later, the Ontario auditor general reported that significant progress had been made to build up a provincial stockpile:

“During an outbreak, health-care workers and patients would need additional protective equipment and medical supplies to protect themselves from the virus. The 2003 Ontario Nurses' Association survey, mentioned earlier in this report, found that more than half of the respondents had concerns about the adequacy of protection they had been given.

Medical supplies such as masks, gloves, gowns, and hand sanitizers are mostly made outside Canada, in places where the influenza pandemic may originate and where border closure is a possibility during a global epidemic. The Ministry had therefore, in early 2007, contracted with a number of vendors to provide a four-week supply of such equipment and



Would not provide N95 masks...we were told we had them but they were locked up somewhere. –ONA member, survey response

supplies for health-care workers who are in contact with patients with infectious diseases. As of March 31, 2007, the Ministry had obtained more than 60% of the required quantities and planned to have all items stockpiled by March 2008.”⁹⁷

According to submissions to Ontario’s Long-Term Care COVID-19 Commission (LTC Commission), the province purchased 55 million N95 respirators in 2008-2009 at a cost of about \$5 million.⁹⁸

By 2017, when the Ontario Auditor General revisited the stockpile, a completely different picture emerged. Eighty per cent of its supplies had expired and it had begun destroying them:

“...more than 80% of these supplies have reached their expiry date. The original cost of the expired supplies is approximately \$45 million. Although the ministry has donated a small amount of supplies to two other countries for emergency situations, it did not put the majority of these supplies into circulation within the health-care system so that they could be used before expiring. The ministry informed us that its budget for these supplies only allowed for storage and not the management of them.”⁹⁹

In a stunning revelation, not only had those supplies been allowed to expire, but no one had thought to circulate them in the health care system before that point.

According to submissions by Ontario officials to the LTC Commission, the stockpile was destroyed without being replenished, and many people in government were aware of this decision:

“COMMISSIONER FRANK MARROCCO (CHAIR): So it would seem to me that you could also say that items were not replenished as they expired.

JESSICA BAUMAN: Yes, that is correct.”¹⁰⁰

Information before the LTC Commission further indicated that, in the wake of the 2017 Auditor General report, the province decided to develop a new stockpile policy before rebuilding the stockpile:

“JUSTINE HARTLEY: ...I would say there was an acknowledgment that the stockpile did need to be rebuilt, but that in order to do that, we needed to undertake the policy review to ensure that we were

creating a stockpile that was sustainable and cost-effective.

JOHN CALLAGHAN: So you are trying to put the policy in place before you acquire a new stockpile; is that correct?

JUSTINE HARTLEY: Absolutely.”¹⁰¹

This policy review had not been completed by the start of COVID-19, and Ontario entered the pandemic with an empty personal protective equipment cupboard. Indeed, the policy review appeared to still be unfinished in early January 2021.

According to submissions before the LTC Commission:

“COMMISSIONER FRANK MARROCCO (CHAIR): You came up with a policy which was basically to keep track of when the PPE [personal protective equipment] is expiring and to use it before it expires, to house it in a way that allows you to identify equipment that’s getting close to expiry so that you can use it?

JESSICA BAUMAN: So what I had come up with by the end of 2020 was a series of thoughts and observations and early recommendations based on the desk analysis that had happened and the review that we had done. However, there was an acknowledgment as well that we still needed to do a little bit more research before making formal recommendations as to how a stockpile should be managed.”¹⁰²

Bottom line: This left Ontario scrambling to purchase personal protective equipment during the pandemic at sometimes exorbitant prices, according to submissions before the LTC Commission:

“JOHN CALLAGHAN: ...You did end up paying considerably more than market price in 2019 in the middle of the pandemic in March of 2020; correct?

JUSTINE HARTLEY: Yes.”¹⁰³

“We learned nothing from SARS,” said one registered nurse in long-term care. *“The government wasted the reserve of N95s.”*

Absence of Transparency

Throughout much of COVID-19, health care workers and their unions were stonewalled when they asked for information about the state of the province’s personal protective equipment supplies.

Ontario Nurses' Association (ONA) President Vicki McKenna said:

"There is a supply problem but government officials will not confirm supply... This question is asked at every meeting with ministry officials."¹⁰⁴

National security expert Wesley Wark echoed her critical comments about the secrecy surrounding personal protective equipment supplies:

"How much usable PPE is in the stockpile is not known... The reasons for this all-out secrecy are hard to fathom."¹⁰⁵

Without a sufficient level of personal protective equipment stockpile disclosure, it is difficult for ONA and other unions to calibrate their recommendations and observations regarding how best to protect health care workers.

It was not until the middle of January 2021 that the province began to disclose more timely and fulsome information on the status of the personal protective equipment stockpile.

That was nearly one year after the pandemic began and long after ONA and other unions had started asking for disclosure. The province has not explained why it took so long to fix an eminently fixable problem.

For a rough sense of what a difference those tens of millions of destroyed respirators might have made, let's consider the findings of a study¹⁰⁶ that examined the possible burn rate – or rate of consumption – in Ontario.

This study estimated that Ontario health care workers using N95s solely for aerosol generating procedures¹⁰⁷ and surgical masks for all other patient contacts would consume 152,174 N95 respirators and 4.5 million surgical masks over a 60-day period.

If those burn rate estimates are accurate, it suggests that the 55 million expired N95s would have allowed Ontario to substitute N95 respirators for those 4.5 million surgical masks and protect its health care workers at a precautionary level for more than 600 days, or nearly two years.

Instead, nurses and other health care workers were forced to ration even surgical masks.

"We were told to make one surgical mask last for the shift," said one nurse in long-term care. *"Then we could have two if needed, but staff would need to ask for them."*

Added a colleague: *"Even regular surgical masks were hard to come by, and the ones we had were of lesser quality than the hospital has."*

Even more scarce were the N95 respirators that worker safety experts said were essential to protect against an airborne disease.

The employer *"would not provide N95 masks,"* said one nurse. *"We were told we had them but they were locked up somewhere."*

Added another:

"Not allowed to use N95. Emphasized needing to save money and conserve, emphasized it was not necessary. Made to feel dramatic when expressing concerns."

Ontario's decision to not replenish its stockpile was a glaring example of being pound wise and penny foolish, for as *The Globe and Mail* noted in an editorial:

*"Set against the approximately \$400-billion in combined federal-provincial deficits the pandemic is expected to deliver this year, the cost of being better prepared is minuscule."*¹⁰⁸

In this vein, Justice Campbell had presciently noted in 2006:

*"Whenever one speaks of cost, the cost to the government to protect us better, the cost to hospitals of better infection control, surveillance, and worker safety, we should never forget the cost of SARS in sickness, pain, suffering, and unspeakable loss."*¹⁰⁹

Failure to Act on PPE Shortages

At the start of the pandemic, Ontario's efforts to replenish its personal protective equipment stockpile were lackadaisical.

Alberta was the gold standard. It maintains a three-month supply of protective equipment, including N95 respirators.¹¹⁰ With one centralized health authority, Alberta uses the bulk buying power of a population of more than four million to get better prices and terms.¹¹¹



They failed to protect us, we should not have had to fight and continue to fight for PPE. –ONA member, survey response

In mid-December 2019, just as the first inklings of possible problems were surfacing in Asia, Alberta's procurement team doubled their regular order for five-days' supply of personal protective equipment, including N95s, gloves and gowns.¹¹² In late December 2019, concerned about news from Wuhan, Alberta bought 500,000 additional N95 respirators.¹¹³

Indeed, Alberta was so well supplied in personal protective equipment that in April 2020 it donated 250,000 N95 respirators to Ontario.¹¹⁴

By contrast, Ontario appeared to sit on its hands during the early days of the pandemic. Not only did it not make any purchases of personal protective equipment in December 2019, as Alberta did, but it appeared to make little effort in January 2020 to acquire supplies of N95s already in wholesale and retail networks in Ontario.

These supplies were being quickly depleted. By late January 2020, drug stores and medical supply wholesalers began reporting that N95 respirators and other supplies were rapidly selling out.¹¹⁵

An official of Wayne Safety, a Toronto area wholesaler of safety supplies, reported there were lineups outside his office in January 2020 that were two or three hours long. He said Greater Toronto Area residents were hearing about the situation in Wuhan from relatives and were buying masks "by the crate" to ship back to their families or hometowns in China.

The wholesaler said Ontario did not start calling until March, but the shelves were long since bare.¹¹⁶

By March 2020, the personal protective equipment shortage had become so dire – and the lack of urgent government attention so worrying – that groups of volunteers began doing what Ontario should have been doing from the dawn of COVID-19.

Medical leaders at Michael Garron Hospital in Toronto organized a campaign to encourage businesses and individuals with personal protective equipment, like masks and gloves, to donate them to health care workers.¹¹⁷

Similar collection campaigns were being formed by volunteers who had been involved in international humanitarian efforts.

Chris Houston, who has worked overseas in health care logistics for various humanitarian agencies, including Doctors Without Borders, said:

"Our group of volunteers started in March what the provincial health authorities should have started in January. We began holding PPE-collection drives at which people and companies dropped off surplus PPE..."¹¹⁸

Instead, Ontario was at the mercy of a "wild west" global market for personal protective equipment characterized by fraud, deception, and chicanery.

A reported example was a failed effort by Ontario to purchase 100 million N95 respirators in early April 2020. Negotiations had gone so far that the province reportedly sent a proof of funds letter to the purported supplier, who it turns out, did not have a relationship with the manufacturer 3M.¹¹⁹

According to *The Globe and Mail*, the province was given an address for a location where the N95s were supposedly stored. The address appeared to have a connection with 3M, so provincial officials called the manufacturer directly to verify the products' availability – only to find out there weren't any. It's unclear why the province hadn't done a sufficiently thorough due diligence review of the supplier.¹²⁰

To demonstrate what was possible on the personal protective equipment front, there's the example of Mariann Home, north of Toronto. As COVID-19 was gaining a footing in Ontario in the first quarter of 2020, Mariann Home's CEO Bernard Boreland said:

"...January 20th...our PPEs were in very good shape, because...I just did my year-end top-up, so we had all of the appropriate N95s and surgical masks... I made some calls to my suppliers in February...that's when they told me that we could expect a shortage of PPE supplies in March and April. So we continued to order the necessary supplies we needed."¹²¹

No resident in the non-profit, 64-bed facility tested positive. One staff member tested positive, but was not the source of any spread in the facility.

A Public Sentinel?

It is troubling that no action was taken to replenish the Ontario stockpile in the roughly two years between the Auditor General's report in December 2017 and the dawn of COVID-19 in January 2020.

It isn't as if this was a secret. Submissions before the LTC Commission indicated that Ontario was fully aware that the N95 stockpile was being destroyed and not replenished.

Ontario's Chief Medical Officer of Health, Dr. David Williams, had a direct line of sight into the stockpile problem. According to a provincial presentation to the LTC Commission, Dr. Williams headed the "Division responsible for stockpile" from 2018 to August 2020.¹²² On his watch, his division destroyed N95 respirators without replacing them, and decided to study the stockpile problem instead of fixing it.

At the start of the pandemic, Dr. Williams offered a rose-coloured assessment of Ontario's preparedness:

"We're ready, we're prepared," he assured the province on January 24, 2020.¹²³

As the people of Ontario would soon find out, this assessment was at variance with the situation on the ground.

Less than two months later, on March 23, 2020, he offered a much less reassuring perspective, suggesting that the province's advance planning was thrown for a loop as it jostled on the global market to purchase personal protective equipment:

"...things changed drastically... The challenge that we found out as we got into it more and more is that the suppliers were dealing with an ever-increasing demand so you're not just ordering on your own volition, you're dealing with a very highly competitive global situation."¹²⁴

Inexplicably, Dr. Williams' agency had apparently not planned for the possibility, in the event of a pandemic, of a mad international scramble for personal protective equipment.

This, in a province that was the epicentre of SARS outside of Asia; that had already faced those exact same kinds of supply-chain problems during SARS; where the SARS Commission warned repeatedly about preventing these equipment shortages ahead of a public health emergency.

It is an open question how someone whose division was in charge of the personal protective equipment stockpile from 2018 to August 2020 appeared to have been caught so unaware – and did not act while there was still time.

The risk of failing to act was widely known to every public health expert who, like Dr. Williams, had gone through SARS, or who was aware of its lessons.

As two witnesses told the LTC Commission:

“COMMISSIONER FRANK MARROCCO (CHAIR): Have I got it right that once there's a pandemic, once, whether it's in January or whenever the world wakes up to the fact that there's a pandemic, it's too late –

BOB BELL: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): – to go out and start buying.

BOB BASS: Exactly.

BOB BELL: True.

COMMISSIONER FRANK MARROCCO (CHAIR): So you either have it, or you're in a spot.

BOB BELL: Correct.”¹²⁵

No Warning Issued

Section 81 of the *Health Protection and Promotion Act (HPPA)*, which also created the position of the province's Chief Medical Officer of Health (CMOH), sets out the officer holder's rights and duties to independently communicate on public health risks and hazards:

- **Annual report**
(4) The Chief Medical Officer of Health shall, in every year, make a report in writing on the state of public health in Ontario, and shall deliver the report to the Speaker of the Legislative Assembly.
- **Laying before Assembly**
(5) The Speaker shall lay the report before the Assembly at the earliest reasonable opportunity.
- **Minister's copy**
(6) The Chief Medical Officer of Health shall deliver a copy of the report to the Minister at least 30 days before delivering it to the Speaker.

- **Other reports**

(7) The Chief Medical Officer of Health may make any other reports respecting the public health as he or she considers appropriate, and may present such a report to the public or any other person he or she considers appropriate.

To better understand the intended purpose of giving the CMOH the power to speak out independently on public health risks, it is informative to return to the statements of the government of the day.

On October 14, 2004, on the recommendation of the SARS Commission, Ontario introduced legislation to create the office of the CMOH and give the office holder independence to speak freely.

Then Minister of Health George Smitherman said:

“In the event of a health crisis, Ontarians want to know that their Chief Medical Officer is free of political concerns and interference... An independent CMOH will be able to put the health and safety of Ontarians first.”¹²⁶

Two months later, on December 16, 2004, legislation to create the position of CMOH received royal assent. In making the announcement, then Health Minister Smitherman said:

“We will have an independent Chief Medical Officer of Health who can act quickly and speak freely on any public health issue without any political interference... The CMOH will be able to put the health and safety of Ontarians first and can speak to the people directly on any important public health issue.”¹²⁷

The statements of the former Health Minister are in line with Justice Archie Campbell’s concerns and assessment. Justice Campbell was acutely aware that as time passes, the urgency of public health emergencies like SARS fade; governments may be less and less willing to devote resources to pandemic preparedness.

History is full of preparedness fading as memories of a disaster dim. Researchers suggest that collective memories of disaster, and of the accompanying community consensus of collective prudence, can dissolve in a generation,¹²⁸ or in nearly as much time as the 17 years that elapsed between SARS and COVID-19.¹²⁹

The question Justice Campbell asked was, as time passes and as memories of a public health emergency fade, who acts as the public’s guardian? Who ensures that the focus on pandemic preparedness is not diminished by time and changing political priorities?

Notably, Justice Campbell recognized that the public health problems exposed by SARS were systemic, years in the making, and resulted from long-term neglect by all political parties:

“These problems developed during regimes of successive governments and no government or political party is immune from responsibility for the decline of public health protection.”¹³⁰

Systemic problems afflict an organization as a whole. They pervade its culture. They are not caused by an individual or a group of individuals. Even if you change personnel or modify organizational charts, systemic problems can persist.

This is implicit in the definition of systemic problems, as “...experienced by the whole of an organization...and not just particular parts of it.”¹³¹

Justice Campbell reasoned that if it took years to create systemic problems, it would also take years, potentially under different governments of different political stripes, to fix them. And, as occurred in the past – as different parties assume power, or hold influential positions in minority government situations, and as memories of a disaster ebb – there is the danger that public health funding could fall victim to changing political winds and stifle efforts to address systemic failings.

Justice Campbell wrote:

“Competition for tax dollars is fierce. It is not easy in a time of fiscal constraint for any government to make additional funds available for any public programme.”¹³²

What was needed, he reasoned, was an independent sentinel to warn legislative assemblies and the public if government neglect risked another disaster like SARS, or worse. He felt that this role of public guardian fit well into public health’s historical role of warning about cigarette smoking, obesity, and other public health risks.

Sadly, Dr. Williams did not follow in this tradition to avail himself of multiple opportunities to act as a public sentinel, warning the public about Ontario’s lack of pandemic preparedness.

Between the Auditor General's 2017 findings and the advent of COVID-19, there is no indication that the CMOH used his powers to warn the public and the Ontario legislature about this significant public health risk:

- In 2018, the CMOH issued an annual report addressing health inequalities. He did not use the opportunity of his annual report to address the issue of pandemic preparedness.
- In 2019, the CMOH issued an annual report titled, "Connected Communities Healthier Together." Again, he did not use the opportunity to address issues of pandemic preparedness.
- Moreover, the CMOH did not avail himself of the power to issue an ad hoc report, as provided under the *Health Protection and Promotion Act*, to warn about Ontario's lack of pandemic preparedness.

Instead, at the dawn of the pandemic, Dr. Williams said on January 24, 2020:

"Ontario is better prepared because of the SARS experience. Through SARS and through all the work later, we have set in place standard policies and procedures... We're light years ahead of where we were in 2003."¹³³

Planned for the Flu

Justice Campbell warned health authorities to be prepared for the unexpected:

"SARS taught us to be ready for the unseen. This is one of the most important lessons of SARS. Although no one did foresee and perhaps no one could foresee the unique convergence of factors that made SARS a perfect storm, we know now that new microbial threats like SARS have happened and can happen again. However, there is no longer any excuse for governments and hospitals to be caught off guard and no longer any excuse for health care workers not to have available the maximum level of protection through appropriate equipment and training."¹³⁴

Instead, Ontario prepared for a pandemic agent that was much better understood: Influenza.

The province's pandemic plan is called the Ontario Plan for an Influenza Pandemic.¹³⁵

In an example of Ontario's focus on influenza as a pandemic agent, the Ministry of Health's online introduction to its most recent pandemic plan (completed in 2013) is leavened with references to influenza:

"When an influenza pandemic occurs, it will likely spread rapidly to all communities in Ontario. A pandemic will trigger implementation of the Canadian Pandemic Influenza Plan, the Ontario Health Plan for an Influenza Pandemic, and local pandemic contingency plans developed during the pre-pandemic and pandemic alert phases.

Response measures will be determined by the epidemiology of the pandemic, the age distribution and severity of the illness, and the efficiency of transmission from human to human. Ontario's response plan for the health care system is based on the best planning assumptions and estimates currently available and may have to be modified if the epidemiology of the outbreak is significantly different than anticipated."¹³⁶

Submissions by Ontario officials before the LTC Commission is further evidence of the focus on influenza in pandemic planning. In discussing the impetus in 2006 for Ontario establishing the personal protective equipment stockpile, influenza was top of mind:

"JOHN CALLAGHAN: ...In SARS, Justice Campbell said, you know, we have got to worry about more than an influenza pandemic. Is this the only stockpile in respect of other types of diseases, for example, a Coronavirus disease such as COVID?

JUSTINE HARTLEY: Yes, so the main impetus for the stockpile in 2006 was to prepare for an influenza pandemic because the monitoring of the threats that were currently going on globally was to do with influenza pandemics, so particularly the H5N1 was thought to be the biggest threat to the health system within Canada, internationally and Ontario, so therefore we would need the appropriate PPE to prepare for that particular event."¹³⁷



Employer was negligent: they did not start preventative measures on time.

—ONA member, interview with ONA counsel

It is worth noting that the influenza planning assumption was still in effect seven years later when the current Ontario pandemic plan was published in March 2013. By that time, the world had experienced two new coronavirus pathogens: SARS, and Middle East Respiratory Syndrome, better known as MERS, an illness caused by a coronavirus that was discovered in September 2012, but may have been circulating in the Middle East as early as April 2012.¹³⁸

It is troubling that Ontario continued to focus on influenza at a time when the world had already come face to face with two novel coronavirus pathogens.

The Ontario Auditor General noted:

“Since the Health Pandemic Plan was developed to deal with an influenza (commonly called a flu) pandemic, some aspects of it, such as guidance on anti-viral medication and vaccinations, were not initially relevant to the COVID-19 virus... As with the Health Response Plan, we noted that some parts of the Health Pandemic Plan are outdated.

For example, the plan:

- does not mention the role and responsibilities of Ontario Health; and
- refers to the Ministry of Health and Long-Term Care, which in 2019 was separated into two ministries.

We also noted that the Health Pandemic Plan did not have, or had only limited, coverage of a number of areas that were critical for the COVID-19 response, including guidance on:

- increasing laboratory testing capacity, speed and reliability;
- contact-tracing capacity;
- range and efficacy of screening for the virus;
- how to balance and deal with competing priorities, such as preserving acute- and intensive-care capacity...”¹³⁹

The mistaken belief that COVID-19 was just like influenza proved to be a characteristic of Ontario’s disappointing pandemic response.

In arguing that surgical masks provided a sufficient amount of protection against COVID-19, a prominent infection control expert, who advises the Ontario government, said the behaviour of influenza could be used as a proxy for COVID-19:

“We have several very high quality randomized controlled trials, using influenza as the marker, that show that an N95 respirator is not superior to the protection you get from a procedure mask... We should use that information. That’s good science.”¹⁴⁰

It is troubling that someone of his stature and influence would claim in March 2020 – at time when we knew precious little about COVID-19 – that influenza could serve as a stand-in for a wholly new pathogen in deciding how to protect health care workers.

By the fall of 2020, at least one high-ranking public health expert conceded that this had been the wrong approach.

In November 2020, Dr. Howard Njoo, the deputy federal Chief Medical Officer of Health, admitted:

“Canada based its pandemic planning on an influenza pandemic and how a respiratory infectious disease typically behaves. But the novel coronavirus had unique characteristics – for example asymptomatic transmission, and airborne transmission by smaller, not just large, droplets – which were not immediately known... Part of my learning was that we never anticipated that.”¹⁴¹

Dr. Njoo’s comments highlight the importance of the precautionary principle, and the damage caused by the failure to follow it and prepare for the unseen, to quote Justice Campbell.

Failure to Create a Workplace Safety Agency

Ontario’s ability to try and dig itself out of its personal protective equipment shortages was hampered by the absence of a significant domestic regulatory capability.

When Eclipse Automation of Cambridge, Ontario developed a new type of N95 respirator, the company had to go to the National Institute for Occupational Safety and Health, better known as NIOSH, in the U.S., to get them certified. Ontario does not have a NIOSH-equivalent certification entity. The process was not rapid because NIOSH “was prioritizing U.S. applications.”¹⁴²

The province could have had the capabilities to regulate a new type of N95 had it implemented Justice Campbell's recommendation to establish our own NIOSH:

- That just as NIOSH, the main U.S. federal agency responsible for worker safety research and investigation, is part of the Centers for Disease Control and Prevention, so the Ontario 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.
- That any section of the Ontario Agency for Health Protection and Promotion involved in worker safety have, as integral members, experts in occupational medicine and occupational hygiene, and representatives of the Ministry of Labour, and consult on an ongoing basis with workplace parties.
- That the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety.
- That the Ontario Agency for Health Protection and Promotion ensure that it become a centre of excellence for both infection control and occupational health and safety.
- That the mandate of the Ontario Agency for Health Protection and Promotion include research related to evaluating the modes of transmission of febrile respiratory illnesses and the risk to health workers. This research should also identify the hierarchy of control measures required to protect the health and safety of workers caring for patients with the respiratory illnesses.¹⁴³

Justice Campbell was impressed not just by NIOSH's regulatory role, but also by the fact that it also:

- Investigates potentially hazardous working conditions as requested by employers or employees;
- Evaluates hazards in the workplace, ranging from chemicals to machinery;
- Creates and disseminates methods for preventing disease, injury, and disability;
- Conducts research and provides scientifically valid recommendations for protecting workers; and
- Provides education and training to individuals preparing for or actively working in the field of occupational safety and health.¹⁴⁴

Justice Campbell also saw an institution based on the NIOSH model as a way to bridge the gap between infection control and occupational health and safety, two solitudes as he called them. In this, he was impressed by NIOSH's multidisciplinary approach. NIOSH's 1,300 employees come

"...from a diverse set of fields including epidemiology, medicine, nursing, industrial hygiene, safety, psychology, chemistry, statistics, economics, and many branches of engineering."¹⁴⁵

While Ontario's public health agency has hired some worker safety experts, these efforts, while commendable, appear to fall far short of Justice Campbell's recommendation of a well-resourced, separate entity modelled on NIOSH that can report independently on health care worker safety issues.

Seventeen years after SARS, amid the failures of COVID-19, Justice Campbell's recommendations are more relevant and important than ever. So was his focus on bringing together all disciplines relevant to keeping health care workers safe.

Many scientists have come to believe that the complex challenges of researching airborne transmission – an important reason why it is called the "the elusive pathway"¹⁴⁶ – require scientific collaboration across a range of disciplines.

One year before the pandemic, this approach was recognized by a group of leading Canadian researchers:

"The transmission of infectious microbes via bioaerosols is of significant concern for both human and animal health. However, gaps in our understanding of respiratory pathogen transmission and methodological heterogeneity persist. New developments have enabled progress in this domain, and one of the major turning points has been the recognition that cross-disciplinary collaborations across spheres of human and animal health, microbiology, biophysics, engineering, aerobiology, infection control, public health, occupational health, and industrial hygiene are essential."¹⁴⁷

It is time that Ontario learned the same lesson, 13 years after it was made by Justice Campbell.

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Chapter 4

The Nexus of the Disaster

4

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Introduction:

To understand how and why things have gone as badly as they have in long-term care, a good place to start is with arguably the worst decision made by Ontario in all of COVID-19.

On March 10, 2020, the province downgraded precautions for health care workers and ditched an effective containment strategy anchored in the precautionary principle. The stated scientific basis for this decision – Ontario’s claim that COVID-19 did not spread through the air – was questionable at the time and has since been proven wrong.

To be sure, retaining the precautionary principle would not have been a magic bullet, making up for decades of neglect in long-term care, or the failure to learn from SARS and prepare for a pandemic.

But, by focusing on both protecting health care workers at a precautionary level and implementing airborne mitigation measures like ventilation and air purification, it could have been our best opportunity to help counter the historical indifference and lack of preparedness that contributed to COVID-19’s heavy burden of death and disease in long-term care.

Precautions are Downgraded

At the dawn of the pandemic, Ontario followed the precautionary principle which, as noted above, on Justice Campbell’s recommendation had been imbedded in the *Health Protection and Promotion Act*, the province’s core public health legislation.

At the time, guidelines required all health care workers to use airborne precautions for novel respiratory infections like COVID-19.¹⁴⁸

However, in the early days of COVID-19, a group of influential Toronto infectious disease experts mounted a powerful public campaign against a precautionary approach.

The campaign started with a March 3, 2020 article in *The Globe and Mail* with the headline: “Ontario’s coronavirus policy for health workers not supported by evidence, experts warn.” The article stated:

“...numerous infectious disease experts say mounting evidence shows COVID-19 spreads through droplets,

such as when an infected person sneezes and coughs, and that airborne precautions are not appropriate nor are they supported by evidence. Instead, they say health professionals should use ‘droplet precautions,’ which refer to gowns, eye guards, gloves and regular surgical masks.”¹⁴⁹

The article, it should be noted, was not balanced with the perspectives of unions and occupational health and safety experts who supported the precautionary principle.

In an example of circular reasoning,¹⁵⁰ this same article was cited in a footnote in an Ontario Public Health document dated March 6, 2020 and titled, “COVID-19 – What We Know So Far About ... Routes of Transmission”¹⁵¹ – as evidence against the possibility of airborne transmission.

Three days after *The Globe and Mail* story, the *Canadian Medical Association Journal* published an article (again by some top infection control experts) recommending that Ontario drop airborne precautions. The article stated:

“Recommendations for use of PPE in the community setting must be evidence based and clearly communicated to all health care workers, and a starting point could be the recommendations put forth by WHO for health care facilities. The approach of using droplet-contact precautions for patients who do not require aerosol-generating medical procedures is aligned with most available data.”¹⁵²

The authors raised the possibility, on the basis of limited evidence, that this precautionary approach might hinder diagnosis of cases at outpatient clinics:

“The provincially recommended personal protective equipment (PPE) and infrastructure required to support airborne-droplet-contact precautions are not routinely available in most outpatient clinics, and this prevents the assessment and testing of low-acuity [Persons Under Investigation] PUI in these settings.”¹⁵³

A few days later, hospital infection control experts wrote a letter addressed to Dr. Williams and leaked to the *Toronto Star*, urging him “to stop requiring the use of N95 respirator masks and other high level infection control measures when treating any coronavirus patients.”¹⁵⁴

At every turn, unions and worker safety experts spoke out against this campaign, though the media appeared to give far greater prominence to the voices of those who opposed the precautionary principle.



The government was unbelievably slow to respond to this pandemic!!!

–ONA member, survey response

What followed was perhaps the greatest failure to learn from SARS during COVID-19.

Bowing to the pressure, Ontario decided on March 10, 2020 that the precautionary principle was not needed and – on the basis of the world’s very limited knowledge of COVID-19 – asserted that it was safe to downgrade health care worker protections from an airborne level to contact and droplet precautions.

Citing his statutory obligation under the *Health Protection and Promotion Act* to “consider the precautionary principle,” Dr. Williams claimed there was sufficient scientific evidence to safely discard the principle:

“The guidance outlined in this directive is a change in current practices respecting COVID-19 based on a better understanding of the epidemiology of the virus and the spectrum of illness that it causes, three months into this COVID-19 outbreak. It has been made in close consultation with Public Health Ontario and I have considered the Precautionary Principle in issuing this directive.”¹⁵⁵

On March 21, 2020, ONA wrote to Dr. Williams challenging both his downgrading of protective measures and his claim that his obligation to consider the precautionary principle had been met:

“It is our view, and that of the experts we have consulted, that this [directive] fails to recognize the foundational importance of the precautionary principle when establishing the guidelines for personal protective equipment (PPE) for those on the front line of this pandemic. Given the uncertainty about modes of transmission, and the experience in both China and Europe, nurses require N95 respirators, not simply surgical masks with poor filtration and poor fit, when caring for patients with suspected or confirmed severe acute respiratory syndrome coronavirus 2 (SARSCoV-2). This is a novel virus, transmission dynamics are not completely known, and the precautionary principle must be applied, as nurses sadly learned from our experience with SARS.”

The Ontario Nurses’ Association (ONA) subsequently went to court to challenge the failure of nursing homes to ensure registered nurses had access to N95 respirators, and thus protect both residents and staff. In a case that highlighted unsafe working conditions at four Ontario long-term care facilities, the court ruled in ONA’s favour.

The judgement disclosed that the main consideration in foregoing a precautionary approach was concern over N95 shortages – a problem of the government’s own making – and not science, and that this had not been publicly disclosed.

In his ruling, Justice Edward Morgan cited the affidavit of the Ontario government’s main expert witness in the lawsuit, which stated:

“It is clear that the supply of N95 respirators is insufficient to provide them for all care for COVID-19 patients, that that supply is unstable, that re-use is fraught with challenges, and that failure to conserve N95 respirators in Ontario is likely to result in them not being available for workers performing AGMPs [Aerosol Generating Medical Procedures] in the future weeks.”¹⁵⁶

In finding in ONA’s favour, Justice Morgan said, “the need to conserve supply...is her [the province’s expert witness] central point” and was not publicly cited as the reason for Dr. Williams’ change of heart on airborne precautions.

Indeed, Michael Hurley, Vice-President of the Canadian Union of Public Employees, which represents 30,000 long-term care home workers in Ontario, recalled hearing

“...Dr. Williams say that when we get the supply problem dealt with, we can return to the precautionary principle, which I think is an admission that the whole watering down of the safety standards is all supply related. It’s not got anything to do with whether people actually believe this is an airborne virus.”¹⁵⁷

Consequences of Discarding the Precautionary Principle

The March 10, 2020 decision to discard the precautionary principle had far-reaching consequences. It continues to exact a heavy price in death, disease, and economic and societal damage.

“Droplet precautions were insufficient with COVID-19 patients,” said one registered nurse. *“The precautionary principle was disregarded completely. Employee and resident safety was disregarded and disgraceful.”*

“The virus is aerosolized,” added another registered nurse. *“Precautionary principle was ignored.”*

The March 10th decision meant that health care workers were not protected at an airborne level when in contact with confirmed and suspected COVID-19 cases.

N95s were reserved for Aerosol Generating Medical Procedures (AGMPs). During an AGMP, the patient’s airways are manipulated in such a manner that produces aerosols potentially spreading a pathogen. An example is an endotracheal intubation in which a tube is placed into the windpipe to open the airway to administer oxygen, medication, or anesthesia.¹⁵⁸

However, registered nurses noted that this guideline failed to take into account the fact that many residents of long-term care may exhibit unpredictable aerosol generating behaviours.

One registered nurse explained:

“The residents...generally have a number of co-morbidities as well, and nearly every resident, at any given time during a shift, could require close contact care.

During such care, these residents often engage in aerosol generating behaviours such as coughing, spitting, choking, spewing, heavy breathing and sneezing.

For instance, we have some residents who suffer from COPD [Chronic Obstructive Pulmonary Disease],¹⁵⁹ who cough regularly and do not always cover their mouths. Some residents require puffers, which have replaced nebulizers due to the pandemic. Many residents cough or choke after using their puffers and it is the RN who usually administers the puffers due to either physical weakness or vision.

This type of care is within less than 12 inches of contact resulting in aerosolized particles being very close to the RN.

Administering medications frequently exposed the nurse to airborne and potentially aerosolized particles.

Many residents must have their medications crushed and in applesauce, yogurt or chocolate syrup. For many residents, the taste is bitter, and they often cough, spew or spit out their medication forcefully. In addition, the nurse frequently must check the resident’s mouth to make sure the medication has been swallowed.

I have one resident who takes her meds whole, but she often spits them up, which means they are covered in saliva and I must try again. Another resident takes her medication whole in applesauce but will only take one of her many bedtime medications at a time. She will put a second one at the tip of her tongue and it must be taken off. She then requires water after each of her minimum eight pills and has a coughing fit after each drink of water, again exposing us to aerosolized particles.

Another resident is also on oxygen via nasal cannula.¹⁶⁰ I must reposition the tubing several times during my shift, which again exposes me to potentially aerosolized particles.”

Another consequence of the March 10th downgrading was that measures against an airborne threat – like increased ventilation, and air purification – were generally put on the back burner.

Instead, the emphasis has been on eliminating transmission via contaminated surfaces. Evidence suggests that this does not appear to be as important a route of transmission for COVID-19 as aerosols.¹⁶¹ This is not to say that attention should not be paid to surface decontamination and hand washing. The point is that these measures were emphasized at the cost of ignoring airborne-related precautionary actions.

To get a sense of how much was foregone, consider the case of COVID-19 outbreaks in health care in the Australian state of Victoria and its largest city, Melbourne. For context, Victoria has a population of about 6.4 million; Melbourne, about five million.

In August 2020, the Victorian government claimed that most of the approximately 3,500 health care workers infected with COVID-19 caught the virus either at home or in the community and brought the virus to work. This was soon shown to be incorrect. Research by the state's Health Department demonstrated that about seven in 10 health care worker infections occurred at work. As in Ontario, health care workers in Victoria wore surgical masks; N95s were reserved for high-risk aerosol generating procedures.¹⁶²

Further investigations pointed to the suspected cause of health care worker infections: Airborne transmission.

"For many months now, it's become clear that airborne spread of the virus is an important control we have to address," said Dr. Julian Rait, President of the Australian Medical Association in Victoria. "So while personal protective equipment (PPE) is important, it's also true that indoors, in poorly ventilated spaces, it's possible for the virus to travel up to five or six metres away given the right circumstances, and this appears to be related to the flow of air inside buildings."¹⁶³

To address this problem, Victoria launched a widespread investigation of ventilation by teams of engineers. They found that in Melbourne hospitals,

"...it is common for air in rooms of sick patients to be funneled into busy corridors, with poor ventilation and airflow issues, the likely cause of coronavirus cases during Victoria's second wave.

Multiple teams of engineers have spent months analysing the airflow in medical wards and treatment rooms after nurses and other health workers began to catch the virus in the hundreds.

Tests that used smoke to measure where air was travelling detected air from patients' rooms circulating at nurses' stations.

Ongoing University of Melbourne tests of the airflow in wards at the Royal Melbourne, Footscray and Sunshine hospitals found it is 'ubiquitous' to have air travelling from hospital rooms out to busy corridors, in all but a limited number of dedicated negative-pressure rooms."¹⁶⁴

Said Dr. Rait: "So therefore ventilation and the turnover of air is very important...if the air is not turning over and people are rebreathing the air all the time, it can increase the risk of getting more severe COVID infection."¹⁶⁵

One wonders what would be found if Ontario undertook similar inspections in long-term care.

Assessing the Evidence Behind the March 10th Decision


It would have been one thing if Ontario had relied on solid scientific evidence to suspend the precautionary principle, and downgrade health care worker protections on March 10, 2020.

Instead, the province's evidence was thin and limited. One university lecturer said privately that he would have failed a student who relied on such a scant basis to support his or her position.

Consider the evidence put forward by the province in the above-referenced March 6, 2020 document entitled, "COVID-19 – What We Know So Far About ... Routes of Transmission."

Released just before Ontario's downgrading decision, the document cites "a recent report from the WHO China Joint Mission on COVID-19 summarizing 75,465 cases [which] indicates that airborne spread has not been reported."

This was partially true. Chinese authorities did not assert that airborne transmission had been proven. But in a troubling omission, the Ontario document failed to acknowledge that, despite the lack of certainty over airborne transmission, the Chinese had taken a precautionary approach and were protecting their health care workers at an airborne level – to good effect.



Chinese infectious disease experts explained:

“...we have adopted a higher standard of protection in China, compared with the World Health Organization guidelines against COVID-19. The main difference is that we used fluid-resistant protective clothing (coverall) with long sleeve and conjoined cap rather than uncapped isolation garment, as well as use [of] respirators (i.e. N95 or European Union standard FFP2) rather than medical surgical masks, in wards dedicated for COVID-19 patients. A respirator, double rubber gloves, eye protection (i.e. goggles or a face shield), coverall and shoe covers were the standard equipment in contacting with COVID-19 patients in China.”¹⁶⁶

This approach was so successful that, as the World Health Organization observed,

“Transmission within health care settings and amongst health care workers does not appear to be a major transmission feature of COVID-19 in China... among the HCW [health care worker] infections, most were identified early in the outbreak...”¹⁶⁷

Another Chinese study stated:

“As of May 8, 2020, 3,514 HCWs with COVID-19 were clinically or laboratory diagnosed in mainland China [about 4.4 per cent of all Chinese COVID-19 cases]... In Wuhan, out of 117,100 HCWs, 2,897 were diagnosed with COVID-19. The overall infection rate [for health care workers in Wuhan] is 2.47%.”¹⁶⁸

Most of the 3,514 infected Chinese health care workers were infected before China went to airborne precautions on January 20, 2020.¹⁶⁹

This wasn't the only instance where the Ontario document appeared to be selective with the facts and failed to tell the whole story.

This document further stated:

“Current evidence suggests that the mode of transmission of COVID-19 is through direct contact and respiratory droplets that have the potential to be propelled for up to two meters.”

This assertion, unfortunately, was not well founded.

One supporting footnote referred to a 2016 infectious disease manual, a reference book published more than four years before the appearance of COVID-19.¹⁷⁰

Another was from a Risk Assessment by the European Centre for Disease Prevention and Control (ECDC). While the risk assessment agrees “there is no evidence of airborne transmission,” it nevertheless, as China did, recommended a precautionary approach and airborne protections:

“Although there is no evidence of airborne transmission so far, ECDC recommends a cautious approach for all patient contacts, with placement of patients in airborne isolation rooms with negative pressure and use of FFP2 or FFP3 respirators with appropriate fit testing.”

What is also troubling is that there was significant evidence from China and Hong Kong, among the first countries impacted by COVID-19, about the importance of taking a precautionary approach, and using airborne precautions.

Chinese doctors and scientists tried to spread this message to the world in a series of studies and articles in leading Western medical journals.

Consider:

- February 6, 2020: A study by Chinese experts offering guidance on the treatment of COVID-19 patients “strongly” recommended that health care workers wear airborne precautions, including N95 respirators, for all interactions with suspect and confirmed cases.¹⁷¹
- February 13, 2020: In another study, Chinese experts warned that asymptomatic COVID-19 patients could spread the disease, concluding that their “...findings warrant aggressive measures (such as N95 masks, goggles and protective gowns) to ensure the safety of health care workers.”¹⁷²
- February 15, 2020: In yet another study into the initial outbreak, Chinese experts warned: “We are concerned that 2019-nCoV could have acquired the ability for efficient human transmission. Airborne precautions, such as a fit-tested N95 respirators, and other personal protective equipment, are strongly recommended.”¹⁷³
- March 5, 2020: In a study in still another journal, Chinese and UK experts used the Chinese pandemic experience to warn other countries that “high-filtration masks such as N95 masks and protective clothing (goggles and gowns) should be used in hospitals where health-care workers are in direct contact with infected patients.”¹⁷⁴
- March 5, 2020 also saw the publication of a study by medical experts in Hong Kong indicating that its health care workers wore airborne precautions for all interactions with suspect and confirmed cases.¹⁷⁵

There are many open questions over China’s actions and transparency during the pandemic. But as Dr. Richard Horton, editor of *The Lancet*, has noted, it is important to not conflate the actions of the Chinese government, including the stifling of whistleblowers, with the commendable efforts of Chinese doctors and scientists who tried to warn the world through articles like those cited above.

Horton said:

“Well, I’d like to distinguish between the Chinese government and Chinese scientists and doctors, because the Chinese scientists and doctors actually worked tirelessly, tirelessly to describe this new disease, to sequence the genome of the virus and to tell the world about it. Now, it is true that we don’t fully know what was taking place in China during December... And that needs to be investigated. But as soon as scientists understood that this was a new virus, they did tell WHO [sic] show and WHO [sic] informed the world about that in very early January. So my view is that the scientists in China actually did a spectacular job of tracking down this agent out of telling the world about it. The failure was on behalf of Western governments for not taking their warnings seriously.”¹⁷⁶

The same comments apply to Ontario. It would have been relatively easy for public health leaders in the province to review the articles or contact these international experts and discuss their findings and perspectives. Whether Ontario public health officials did so is an open question. Even if they did, Ontario did not change course.

Despite the guidance from Asia and growing evidence of airborne transmission, Ontario public health leaders and their advisors have steadfastly maintained their aversion to the precautionary principle, and to the possibility of airborne transmission.

- In May 2020, an infection control expert said: “The reason we know [COVID-19 is not airborne] is because...we have hundreds of health care workers who are taking care of patients wearing regular masks... If this [were] airborne...all these health care workers would be getting sick.”¹⁷⁷
- In a May 2020 letter to a major Canadian newspaper, a group of infection control experts wrote: “If COVID-19 were an airborne infection...we would see large and widespread outbreaks in places adhering to droplet prevention...we have not.”¹⁷⁸
- In July 2020, with COVID-19 infections soaring, another infectious disease expert said that if surgical masks and other contact and droplet precautions “didn’t work, we would see vastly higher numbers in our health care workers.”¹⁷⁹



Did not have sufficient N95 masks. They were locked up and had to ask management if we needed any. –ONA member, survey response

One registered nurse in long-term care, who worked through SARS and was very familiar with Justice Campbell's report, was despondent that its lessons were largely ignored.

"They were not prepared," added another registered nurse. *"I asked to see their pandemic plan in January of [2020] and they did not have one."*

A third colleague added:

"Worked directly in contact with COVID-19 patients and poor PPE supply and extreme staff shortage and no adequate staff to care for COVID-19 patients. No COVID-19 policy. No pandemic policy. Poor management to protect patients and staff."

Dr. Horton called the Western response to SARS-CoV-2, the virus that causes COVID-19, "the greatest science policy failure in a generation. The signals were clear."¹⁸⁰

Dr. Horton was referring to the failure to follow a precautionary approach – and to learn from other jurisdictions like China, Taiwan and Hong Kong, whose policies and procedures were based on protecting their health care workers and public against an airborne pathogen.

As evidenced in this report, the same could be said about Ontario. But with one significant difference. The countries, such as the U.K. and the U.S., that Dr. Horton likely had in mind in making his comments had never experienced SARS and had never had the opportunity to learn from SARS and put its hard-earned lessons into practice.

Unlike China, Taiwan and Hong Kong, who, the evidence suggests, learned from SARS, Ontario had that opportunity, but failed miserably to take advantage of it.

On a broader level, Dr. Horton's critique points to a more fundamental problem, the failure of public health agencies in the West, including in Ontario, to listen to China's experts.

As a possible explanation, Horton of *The Lancet* cited Western exceptionalism:

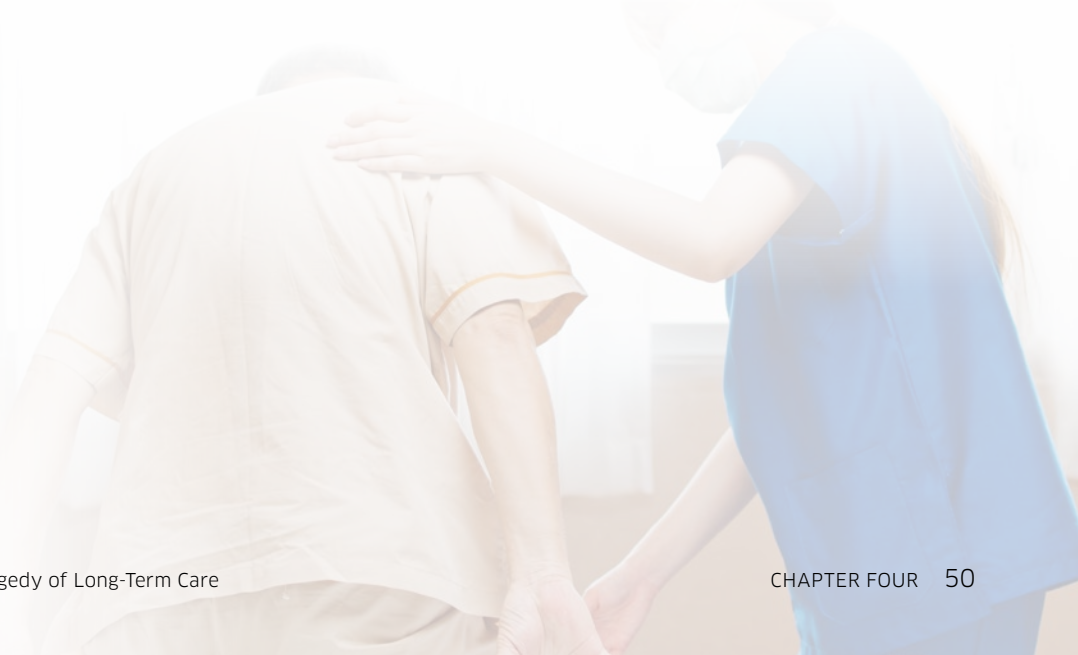
"There was a general skepticism combined with exceptionalism. We thought our health systems are better. Our scientists are better. Our doctors are better. And we will be able to handle this better than the Chinese have done. This is why tens of thousands of our citizens died, and they didn't need to die."¹⁸¹

Dr. Saverio Stranges, who chairs the Department of Epidemiology at the University of Western Ontario's medical school, echoed that sentiment:

"From our Western arrogance, sometimes we believe that our systems are the best and there is nothing to be learned from other countries, especially, if you are like, from the Asian continent," said Stranges, who has worked in Europe, Canada, and the U.S. "But in these systems, I think there is a lot that can be learned in terms of emergency preparedness for either a second wave or even for the next pandemic."¹⁸²

In a related article in a medical journal, Stranges added that this failure has cost Canada and other Western countries dearly:

"In case of the ongoing COVID-19 pandemic, most western countries have missed the boat by not using the golden window period at the early days of the spread of epidemic that the East Asian countries used to halt the COVID-19 epidemic."¹⁸³



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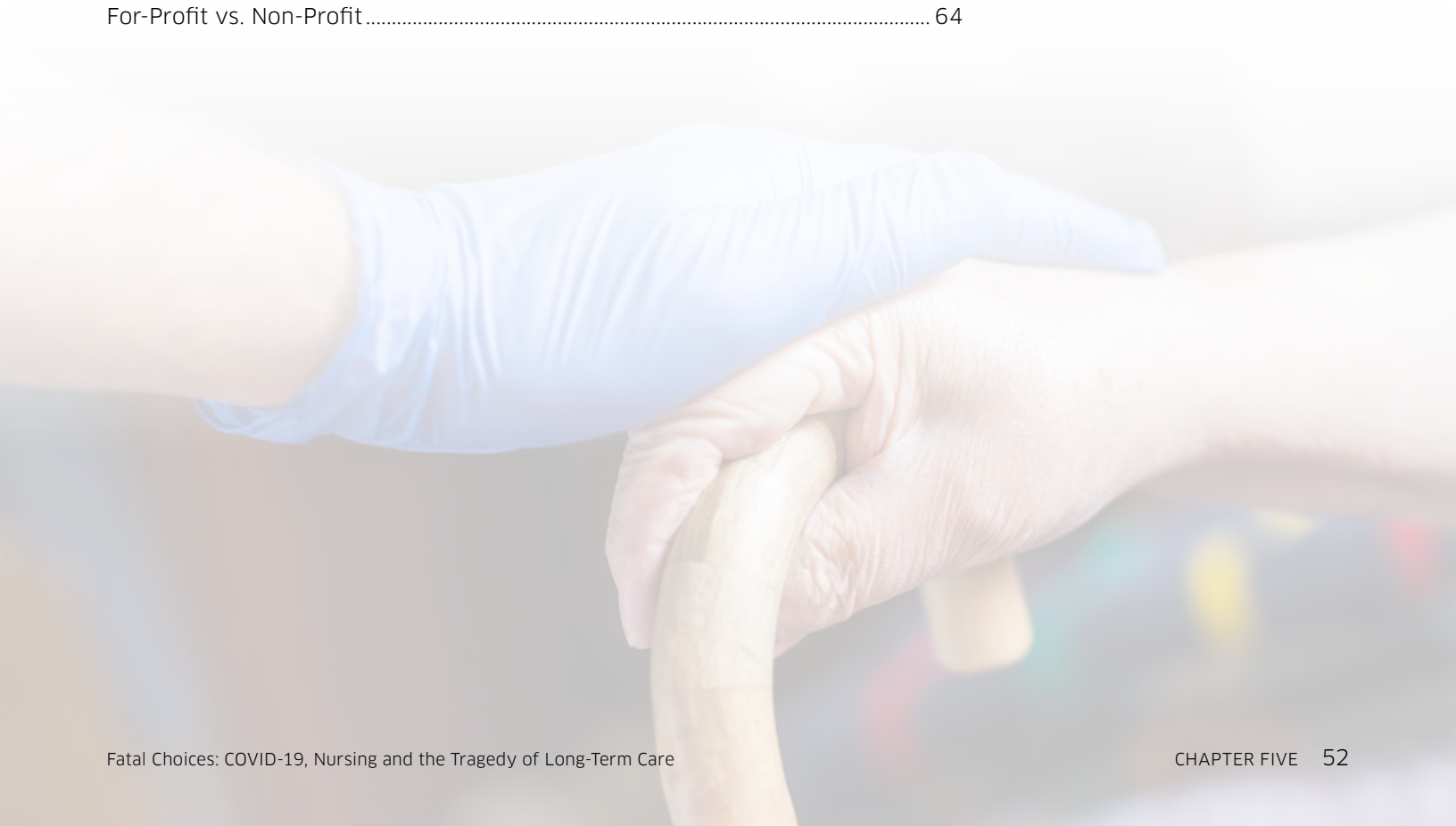
Chapter 5

Long-Term Care, A Troubled Past

5

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Introduction:

“History,” the Canadian writer Graydon Carter once said, is “an epic tale of missed opportunities.”

The same could easily be said about Ontario’s long-term sector. Its history is a long, troubled tale of missed opportunities.

They form two narrative strands, often intertwined, alternating between the promise of substantive change and the disappointment of inaction and inertia.

The first narrative strand involves the myriad of problems that have afflicted long-term care for decades: unsafe staffing levels, critical shortages of registered nurses,¹⁸⁴ overcrowding, under-funding, outdated infrastructure, and poor ventilation systems.

They have been identified in at least 13 investigations, including two coroner’s inquests, and the provincial Long-Term Care COVID-19 Commission. Often spurred by a disease outbreak or a violent incident, these inquiries diagnosed long-standing systemic failures and recommendations to rectify them.

But there was no political will to fix them under successive governments.

Compounding these problems is the fact that nearly 60 per cent of Ontario nursing homes are for-profit entities. Outbreaks in for-profit homes resulted in nearly twice as many resident infections, and 78 per cent more resident deaths, than non-profit homes, according to Ontario’s COVID-19 Science Advisory Table. It ascribed these poorer outcomes to the for-profit sector’s older infrastructure.¹⁸⁵

Keep in mind, however, that over the past decade, the province’s three largest for-profit operators reportedly paid out \$1.5 billion in profits to shareholders.¹⁸⁶ That \$1.5 billion could have gone a long way to fixing their facilities’ infrastructure problems. Instead, for-profit operators made a conscious decision to pay dividends to shareholders instead of improving conditions that are known to have contributed to COVID-19’s death and destruction.

The second narrative strand of missed opportunities involves the failure to fix one of the most important problems identified by Justice Archie Campbell

during SARS – the chasm between infection control and occupational health and safety, a divide that he described as “two solitudes.”

In investigating the 2003 outbreak, Justice Campbell observed that infection control – grounded in an outdated large droplet theory¹⁸⁷ that, unfortunately, still remains a cornerstone of public health – dismissed the possibility that SARS could spread through the air and eschewed a precautionary approach.

Registered nurses, unions and occupational health and safety experts, on the other hand, were precautionary, warning that there were too many unknowns to rule out SARS’s airborne potential. Health care workers, they argued, needed to be protected with airborne precautions while the science was uncertain.

Justice Campbell concluded:

“In Ontario, infection control and worker safety disciplines generally operated as separate silos during SARS. Until this divide is bridged and infection control and worker safety disciplines begin to actively and effectively cooperate, it will be difficult to establish a strong safety culture in Ontario.”¹⁸⁸

Ontario did not learn this lesson from SARS. This failure combined with the failure to fix long-term care’s endemic problems to create an environment “ready-made for a respiratory virus to run rampant.”¹⁸⁹

As a registered nurse explained to the Long-Term Care COVID-19 Commission:

“We knew decades ago when SARS hit that all of this was possible, but they didn’t – they didn’t choose to put the money where it needed to go. They didn’t choose to increase infection control, cleaning, focus on health and safety. They let the residents remain in old, antiquated buildings that were so close together that four people shared a bathroom. There was no – there was no other end result than what we have now because they didn’t learn their lessons.”¹⁹⁰

In this chapter, we will examine the two narrative strands of missed opportunities with a focus on the following four themes:

1. The “two solitudes” of infection control and occupational health and safety;
2. The outdated infrastructure in long-term care;
3. Staffing; and
4. For-profit homes.

A Tale of Two Solitudes

To resolve the “two solitudes” problem, Justice Campbell pointed to the possible solutions offered by a Health Canada manual published in 2002.

It regarded infection control and occupational health and safety, not as separate silos, but as two collaborative, complementary sides of the same coin, with infection control as the lead on protecting patients and residents, and occupational health and safety filling the same role on worker safety.¹⁹¹

The Health Canada manual highlighted the benefits of close cooperation between the two disciplines:

“A component of the [worker safety] program relates specifically to infection control and must be planned and delivered in collaboration with the Infection Control (IC) program of the workplace... This document supports the close collaboration of [Occupational Health and Safety] OH personnel with those responsible for the IC program... It notes the essential collaboration of both groups working together where responsibilities overlap, especially in the management of outbreaks.”¹⁹²

The Health Canada manual’s approach was consistent with the SARS experience at Vancouver General Hospital. It received B.C.’s SARS index case on the same day in March 2003 (and within a few hours) of the Ontario index patient arriving at Scarborough Grace Hospital in Toronto.

Vancouver General’s precautionary approach quickly led to isolating the index patient and protecting health care workers with airborne precautions, thereby stopping the B.C. outbreak in its tracks. Scarborough Grace did the exact opposite, opening the door to Toronto’s disastrous SARS outbreak.

Justice Campbell wrote:

“When dealing with an undiagnosed respiratory illness, health workers at Vancouver General automatically go to the highest level of precautions and then scale down as the situation is clarified. While the circumstances at Vancouver General and the Grace [Hospital] were different, it is not surprising that SARS was contained so effectively at an institution so steeped in the precautionary principle.”¹⁹³

It was bad enough that the long-term care sector’s ability to fight COVID-19 was compromised by historical failures to fix its systemic problems.

What made the situation worse – and exacerbated the sector’s systemic failings – is that the “two solitudes” remained in place during the pandemic.

Nursing homes’ COVID-19 response was hamstrung by public health guidelines grounded in the same dynamics as in SARS. The following quote from Justice Campbell is as true today as it was in 2006 when he completed his report:

“Infection control relied on its understanding of scientific research as it stood at the time. Worker safety experts relied on the precautionary principle that reasonable action to reduce risk should not await scientific certainty.”¹⁹⁴

Justice Campbell also noted that there were deficiencies in both infection control and worker safety systems in containing SARS outbreaks:

“The stories of the outbreaks at Scarborough Grace Hospital and North York General Hospital reveal the systemic province-wide inadequacy of preparedness, infection control and worker safety systems.”¹⁹⁵

This was grounded in part due to a lack of expertise in both areas:

“There was a grave lack of worker safety expertise, resources, and awareness in the health system, a lack whose impact was compounded by a similar lack of infection control expertise and resources.”¹⁹⁶

The SARS Commission also addressed the state of infection control that existed in the health care system prior to SARS.

“When SARS hit in 2003, it revealed a system wide underemphasis and decline in infection control practices and standards.”¹⁹⁷

SARS cited a key study that summarized the results of a survey sent to acute care hospitals about their infection control practices. The study revealed the poor state of infection control in hospitals, leading to the conclusion that “hospital infection control was inadequate throughout Ontario.”¹⁹⁸

Which brings us to a central recommendation of many long-term care inquiries: The importance of having an infection control practitioner in every long-term care facility.



I feel utterly unsupported as a nurse now. I feel disposable, replaceable.

—ONA member, survey response

The coroner's inquest at Central Park Lodge is a case in point.

Central Park Lodge was a for-profit long-term care home in Kitchener with 240 beds and approximately 200 staff. It now operates under the name Forest Heights.

Between December 1998 and January 1999, it suffered an outbreak of Influenza A, infecting 82 residents and 49 staff members. Approximately 25 residents died during that time period, 18 of those deaths were subsequently determined to have been directly caused by Influenza A.

At a subsequent inquest, the jury made 25 recommendations. While many were specific to influenza, there were others that were relevant to outbreak management more generally.

The jury heard evidence about the lack of qualified infection control practitioners in the long-term care sector. During this particular outbreak, the infection control practitioner was on vacation and there was no one with comparable expertise covering for her.

As a result, the jury made the following sound recommendations:

- All [long-term care facilities] to have a provincially funded Infection Control Practitioner (ICP). When the ICP is away/unavailable, there should be appointed in his/her absence an appropriate trained designate. When the number of ICP in the area reaches an appropriate level, they should develop a "coverage" arrangement like we know that physicians and Medical Officers of Health employ.¹⁹⁹
- Infection Control Practitioners in [long-term care facilities] should ensure that surveillance data from throughout the facility for residents and staff are collated and reviewed by one individual at least once daily so that the occurrence of an outbreak can be promptly suspected. During flu season data should be collated and reviewed twice daily.²⁰⁰

This recommendation was reinforced in the recent interim measures put forward by the Long-Term Care COVID-19 Commission:

"Continuing to strengthen IPAC measures is critical to protect residents, staff, visiting families and caregivers from outbreaks. In this regard, we recommend the following:

1. Ensure every LTC home has a dedicated IPAC lead who can monitor, evaluate and ensure compliance with proper protocols; support and provide basic training for all staff, and access the local IPAC centre of expertise, as required.
2. Enhance LTC ministry resources and capacity to provide compliance support immediately. In the short term, inspection staff from your ministry and others who can be trained, as well as from the local Public Health Unit, should be sent into homes to conduct timely, focused inspections to ensure homes are properly implementing proactive IPAC measures, and are responding effectively to their assessment results."²⁰¹

These recommendations are important in improving infection control in long-term care. However, they only address half the problem.

They rely on infection control to protect not just residents, but also health care workers, and COVID-19 has demonstrated that health care worker safety is outside their expertise, training, and professional perspective.

When there is scientific uncertainty, to paraphrase Justice Campbell, infection control relies on its understanding of scientific research as it stands at that time. Its actions are grounded in the certainty of what is known.

Worker safety experts rely on the precautionary principle that reasonable action to reduce risk should not await scientific certainty.²⁰²

This approach is highlighted in the 2011 guidance prepared by a committee established in 2006 under Section 21 of the *Occupational Health and Safety Act* "to advise and make recommendations to the Minister of Labour on matters relating to occupational health and safety of all health care workers in Ontario."²⁰³

The guidance stated:

“The precautionary principle in this guidance note is an approach for protecting workers in circumstances of scientific uncertainty, reflecting the need to take prudent action in the face of potentially serious hazards without having to await complete scientific proof that a course of action is necessary.”²⁰⁴

An example of the profound difference between this approach and that of infection control is a February 2021 presentation to stakeholders by a provincial agency known as Ontario Health, whose mandate is “to connect and coordinate our province’s health care system in ways that have not been done before.”²⁰⁵

Entitled “Ontario Health Province-Wide Personal Protective Equipment (PPE) Knowledge Exchange,” the webinar had a provocative sub-title: “PPE Myth Busting.”

The accompanying PowerPoint – prepared by two Public Health Ontario infection control specialists – contained the following misinformation as part of its “Myth Busting” effort:

“A level 1 mask [i.e., a surgical mask] is protective against droplet transmission and therefore will protect against COVID-19.”

“Myth: We need to wear N95 respirators when caring for patients/residents/clients with COVID-19.

Truth: A medical mask is protective against COVID-19.

COVID-19 is transmitted primarily via droplets during close, unprotected contact (within 2 metres).”

This presentation is grounded in what the discipline of infection control believes it knows for certain. In the process, it perpetuates the now disproven theory that COVID-19 does not spread through the air, and that surgical masks are sufficient protection for health care workers treating COVID-19 cases. It does so, despite all the evidence to the contrary, and the airborne transmission acknowledgements of the Public Health Agency of Canada and other public health bodies.

When hospital-based infection disease experts were seconded to long-term care facilities during COVID-19, they delivered a similar message over and over to registered nurses.

If we’re going to protect staff in long-term care, the divide between infection control and occupational health and safety must be bridged.

Strengthening Worker Safety Systems

Justice Campbell found a persistent and pervasive lack of attention to worker safety during SARS:

“The Commission finds that there was a systemic disregard for the importance of protecting health care workers from occupational hazards such as exposure to an infectious disease. Rather than start with a high, broad-based approach to protection and scale back as the risk became clearer, the opposite occurred: Protection for health workers increased as the risk became clearer. This meant that the learning about appropriate level of precautions came at a terribly high price, as precautions increased as health workers became ill.”²⁰⁶

Justice Campbell itemized the factors that led to a poor worker safety system in Ontario, which he characterized as “deep structural contradictions” in worker safety:

- A profound lack of awareness within the health care system of worker safety best practice and principles.²⁰⁷
- The sidelining of the Ministry of Labour during SARS and not having central responsibility in protecting health workers, instead largely deferring to the Ministry of Health and the health care system to ensure health care workers were protected.²⁰⁸
- The failure of the Ministry of Labour to proactively inspect SARS hospitals until June 2003, when the outbreak was virtually over.²⁰⁹ The Ministry of Labour did not get involved for large outbreaks during SARS²¹⁰ and instead deferred to public health officials, which resulted in workers not effectively being protected.²¹¹
- Unlike British Columbia where directives were built on the dual expertise of infection control and worker safety experts, in Ontario the directives issued by the Ministry of Health lacked sufficient worker safety input, focused solely on personal protective equipment to the exclusion of other protections for health care workers, the requirement for fit-testing of N95 respirators, and the requirement to follow provincial laws.²¹²
- The failure of employers to follow public health directives and the failure of the Ministry of Labour to enforce the directives until after health care workers complained and had contracted SARS.²¹³
- The systemic failure to see the importance of ensuring that the Ministry, unions, and worker safety experts were all at the table as integral partners in the fight against SARS.²¹⁴

- British Columbia deployed joint teams of worker safety and infection control experts to urgently address any infections and to prevent further transmission in the hospital. These teams made sure the health workers knew proper procedures, were fit-tested, and had the latest information on SARS. By contrast, in Ontario there was a lack of in-house occupational health and safety experts such as occupational hygienists working and guiding the response to SARS.²¹⁵

The fact that many hospitals lacked qualified worker safety specialists and the consequence of relying solely on infection control experts was recognized as a systemic failure.

In this regard, Justice Campbell quoted in his final report from a submission by a hospital with a strong occupational health and safety program:

“Many health care organizations do not have appropriately qualified occupational health and safety staff and thus have to rely on infection control practitioners where available. This leads to significant gaps in the protection of staff, as infection control practitioners are qualified to address the control of communicable disease within a patient care population, rather than applied biosafety for the protection of staff. Infection control practitioners do not receive master’s level training in aerosol dynamics, respirator performance, engineering controls, ventilation etc. and are not trained to conduct risk assessments relative to the range of biological hazards for which staff protective measures, such as the use of biosafety cabinets, need to be established.”²¹⁶

Occupational health and safety experts regard N95 respirators and personal protective as the last – rather than the first – line of defence against workplace hazards. They recommend that personal protective equipment should be utilized not in isolation, but within a holistic, coordinated system of infection prevention controls, known as the hierarchy of controls.

The hierarchy of controls is a fundamental principle of worker safety and includes engineering and administrative controls in addition to personal protective equipment. Engineering controls address the hazard as its source such as enclosing it or using local exhaust ventilation. Administrative controls refer to programs and processes to ensure early recognition and appropriate placement of patients who are infectious, surveillance for detection of outbreaks, adequate cleaning and disinfection of the environment

and education programs for health care workers about identifying and managing risk.²¹⁷

Justice Campbell repeatedly recommended strengthening both worker safety expertise, infection control, and bridging the two solitudes throughout his recommendations:

- That in future infectious disease crisis, directives be jointly prepared by worker safety and infection control experts;
- That the Ministry of Health and Ministry of Labour jointly establish teams of infection control experts, occupational hygienists and labour inspectors to rapidly deploy to workplace outbreaks; and
- That the future planning agency for pandemics, the Ontario Agency for Health Promotion serve as a model for bridging the two solitudes of infection control and worker safety.²¹⁸

Above all, Justice Campbell emphasized collaboration and an equal partnership between infection control and worker safety.

The long-term care sector has suffered the greatest consequence for the failure to have not only strong infection control leads in nursing homes but ensuring there is adequate worker safety expertise to work jointly in preventing the transmission of COVID-19, otherwise the mistakes of SARS will be repeated.

Unfortunately, this was the case at Seven Oaks, where the lessons of SARS were not heeded.

Seven Oaks – A SARS Footnote

In the fall of 2005, a mysterious outbreak swept through the Seven Oaks long-term care facility in suburban Toronto, infecting 70 residents, 39 staff, 21 visitors and five other people who lived or worked nearby. Twenty-three residents died.

The outbreak raised concerns that SARS might have returned. So much so that CNN even sent a reporter to cover the Seven Oaks outbreak. This proved to be a false alarm.

The causative agent turned out to be Legionella, a bacterium found naturally in freshwater environments. Inhaling it causes Legionnaire’s Disease, a severe form of pneumonia.²¹⁹ At Seven Oaks, it had been released from a water-cooling tower.

To investigate, the Ministry of Health appointed a panel of three highly respected physicians with SARS experience. They generated a report which said:

“The Legionnaires’ outbreak was the first time since SARS in 2003 that Ontario faced the threat of an illness that could not be easily or quickly identified. It was also the first opportunity to test the lessons learned from SARS.”²²⁰

Justice Archie Campbell concurred: The Seven Oaks outbreak was an opportunity to assess progress since SARS, especially in a long-term care environment that had been spared during the 2003 outbreak.

What he found, however, was troubling:

“Seven Oaks demonstrated that many worker safety lessons of SARS have not been learned.”²²¹

What was problematic was how the Ministry of Health and Long-Term Care (MOHLTC) investigation was structured and conducted.

Justice Campbell wrote:

“When the Centers for Disease Control and Prevention (CDC) sent a team to Toronto to investigate the infection of nine health workers at Sunnybrook on April 13, 2003, for example, no one thought to notify the Ministry of Labour that a worker safety investigation was being conducted at Sunnybrook.

Two years after SARS, the Seven Oaks panel investigated an outbreak in a workplace where nearly 30 per cent of the victims were workers, but the Ministry of Labour was not an integral partner in the investigation and the panel’s membership did not include a worker safety expert.”²²²

The Ministry of Labour was sidelined at Seven Oaks as it had been during SARS – and as it would be again, to a notable extent, during COVID-19. Then, as now, the MOHLTC occupied “worker safety territory, where one would expect greater presence and collegial involvement by the Ministry of Labour.”²²³

“Seven Oaks,” observed Justice Campbell, “showed the bad side of Ontario’s response to SARS’s systemic

problems that remain unfixed; the problems of the provincial laboratory; the two solitudes between infection control experts and worker safety experts; the exclusion of the Ministry of Labour from the centre of the investigation and the subsequent report...”²²⁴

The Seven Oaks report also recommended that the Ministry of Labour’s worker safety standard setting powers be given to the Ministry of Health.

Justice Campbell was sharply critical of this suggestion, which was never carried out:

“SARS demonstrated that worker safety requires an independent regulator with two important roles. First, the regulator must be responsible for the development of worker safety standards that reflect the latest scientific research, occupational health and safety expertise and best practices, and the standards recommended by other agencies, such as the National Institute for Occupational Safety and Health (NIOSH). Second, once safety standards are set, the regulator must ensure that all workplaces are aware of and in compliance with those standards.

It would be improper for the Ministry of Health, as the Ministry that funds and oversees the health care delivery system, to regulate itself and the system for which it is responsible. This would place it in an untenable position.”²²⁵

Most troubling, the Seven Oaks report took a hard stance against a precautionary approach to the level of personal protective equipment health care workers should wear in the face of an unknown hazard. The physicians who authored the report stated:

“While many may think that, in terms of infection prevention and control, ‘more is better’ – that is not the case. There are serious and inherent risks – to health care providers, to patients and to the system – in using higher-level precautions when they are not required.”²²⁶

Echoing similar comments and arguments made during COVID-19 by public health agencies and their advisors, the Seven Oaks report listed what its authors claimed were risks related to what it believed was an inappropriate use of the higher-level precautions. These



We were doing a lot of care that would typically be provided in hospital in the long-term care home. –ONA participant, Commission Group Panel

alleged risks were presented as established fact but no supporting evidence was provided. They included:

- Personal protective equipment is uncomfortable and difficult to put on, so it is often misused or worn improperly;
- Errors are more common;
- Workers tend to become over confident in their equipment and neglect other key measures, such as hand hygiene;
- Health care providers experience health problems (e.g. rashes, problems breathing);
- Patient care may suffer; and
- It is costly and uses supplies that may be required when the system is faced with diseases that require that level of protection.

In response, the Ontario Nurses' Association (ONA) took issue with these unfounded arguments against the precautionary principle, stating in a letter to the province:

"A day in the life of a health care worker is replete with all varieties of discomfort. While health care workers (like all workers) would prefer not to wear respirators, they are prepared to adjust to discomfort when necessary to make the very air they breathe safe for themselves and safe to pass on to patients and family. Firefighters, steelworkers, chemical workers and others have for decades routinely crouched in cramped, confined spaces for hours at a time, dragged down by heavier respiratory protection than the N95 respirators... Given information and training about hazards and the need for respiratory protection, all workers tolerate the discomfort."²²⁷

The Seven Oaks outbreak, Justice Campbell wrote,

"...demonstrates the continuing reluctance of the health system to fully accept the importance of the precautionary principle in worker safety. Until this precautionary principle is fully recognized, mandated and enforced in our health care system, nurses and doctors and other health workers will continue to be at risk from new infections like SARS."²²⁸

The continued operation of the two solitudes continued during the 2005 outbreak at Seven Oaks. Now 17 years after SARS, and 15 years after the Legionella outbreak

at Seven Oaks, COVID-19 in the long-term care sector has revealed how entrenched – and influential – this compartmentalization has remained.

Old Buildings: Poor Infection Control

The Ontario Auditor General found in 1995 that 68 nursing homes with approximately 7,000 beds, "were so deficient they required major renovations or complete reconstruction to meet existing minimum structural and environmental standards."²²⁹

Six years later, in 2001, according to a subsequent Auditor General audit of long-term care, progress had been anemic with only 42 per cent of operators of the most problematic facilities agreeing to rebuild their facilities, let alone actually completing those improvements.²³⁰

Changes in 1998 to Ontario's structural safety standards for long-term care meant that nursing home rooms could no longer house more than two residents in a room. However, under the legislation, existing homes were grandfathered in and allowed to operate under a previous standard from 1972, which allowed for rooms with up to four beds.

A CBC investigation in June 2020 found that a third of the 78,163 beds in Ontario's homes remained at the 1972 standard. It also found that these beds disproportionately account for COVID-19 deaths: 57 per cent of the province's reported COVID-19 deaths in long-term care homes in the first wave were in overcrowded wards.²³¹

In addition, according to the CBC, most of the substandard beds (about 80 per cent) remaining in Ontario are in for-profit homes, meaning about half of the beds in for-profit facilities are still at the 1972 standard or below.²³²

Registered nurses and other health care workers raised the alarm very early in the pandemic that some of these overcrowded homes were failing to properly isolate and cohort residents who had tested positive for COVID-19.

Experts say there's an obvious fix to the infrastructure issue:

"So how can we ensure our homes are safe for all? We can design them so that more people can live in single-bed rooms, with enough space to spread them out in the event that they need to be isolated," said Dr. Samir Sinha, Director of Geriatrics, Sinai Health System and University Health Network.²³³

Chronic Staffing Shortages

Staffing has – and continues to be – a major problem in long-term care, putting residents at risk.

There are two aspects to staffing: one is staffing shortages that pre-dated COVID-19; the other, a need for extra staffing in times of emergencies and outbreaks.

On the former, there have been many studies focusing on the needs of residents in long-term care, the number of hours of care received by nurses and other health care workers, and their relationship to staffing.

In a landmark study conducted by Price Waterhouse Cooper 20 years ago in 1991, Ontario was compared to other jurisdictions to assess whether residents in long-term care homes were receiving the care they needed.

The study found that Ontario residents were sicker than those in other jurisdictions such as Saskatchewan, Manitoba, Maine, Michigan, Mississippi, South Dakota and Sweden: Ontario long-term care residents were amongst the oldest, had one of the highest rates of dementias and Alzheimer's, had the highest proportion of residents with stroke in the Canadian sample, had high levels of cognitive and ADL (activities of daily living) impairment and are the most depressed.²³⁴

Remarkably, despite the higher needs of residents, the study found that in almost all cases, residents in Ontario long-term care facilities on average received less nursing, health care aide, and therapy care than found in the majority of comparators.

Ontario provided the fewest number of nursing hours per resident per day, and also had the lowest amount of care provided by registered nurses.

On average, Ontario seniors at nursing homes see an on-site registered nurse – who typically supervises 60 residents on a day shift and 100 residents on a night shift – barely 15 minutes per day. That ranked last on the study's list.²³⁵

For the combined time residents get per day with registered nurses and health care aides, Ontario again ranked last. Seniors in Maine and Mississippi received an average of four hours a day of quality care. Long-term care residents in Saskatchewan, South Dakota, Michigan and the Netherlands all got more than three hours per day. Ontario's average was two hours per day, mostly with attendants who had fewer qualifications and were paid less than registered nurses.²³⁶

No action was taken following this report.

It was, however, followed by more studies under successive governments who vowed to change long-term care. One such study was commissioned 13 years later in 2004 by then Minister of Health George Smitherman who asked Monique Smith to review long-term care homes in the province.

This report was intended to act as a blueprint for “revolutionizing” long-term care in Ontario. The study focused on a number of areas, including improved staffing.

Ms. Smith acknowledged that some homes experienced very challenging staffing issues. As an example, she recounted that one home had only one registered nurse, one registered practical nurse and four health care aides for 160 residents on the night shift.

She also noted that homes relied on part-time staff, resulting in a “casualization” of the work force. Outside agency staff were used. All of these problems resulted in greater staff turnover and the opportunity for increased error. She recommended that more full-time staff were required to provide “consistent, resident-knowledgeable care.”²³⁷

Although the staffing issue was not substantively addressed, Ms. Smith's efforts did lead to a new law, the *Long-Term Care Homes Act*, that was seen as a legislative improvement. The structural problems rooted in poor staffing remained untouched for another day.

Five years later, tragically, a long-term care resident at Casa Verde, a nursing home in Toronto, murdered two fellow residents. A coroner's inquest was held in 2005 and the jury issued 85 recommendations aimed at preventing deaths in similar circumstances.

Again, the jury called for improvements for funding and staffing to meet the mental health needs of residents:

“That the MOHLTC, in consultation with stakeholders, should revise the funding system presently in place for LTC [long-term care] facilities...any new system... presently being contemplated...should be designed to ensure that the funding model is sufficient to take into account the higher skill level of staff required for residents with dementia and other mental health problems and, in particular, give sufficient weight to actual and potential aggressive behaviours to ensure adequate staffing, sufficient time and resources for LTC [long-term care facilities] if they are responsible to manage residents with such behaviours.”²³⁸

Despite two residents losing their lives, no improvements to staffing followed this Inquest.

In 2007, the then Minister of Health and Long-Term Care, established an independent review of staffing and care standards in Ontario. Shirlee Sharkey was appointed to lead the review. Sharkey's recommendations focused, in part, on strengthening staffing capacity for better care.

Well before the COVID-19 pandemic, Ms. Sharkey recommended that the government develop guidelines for annual funding that would support "...a provincial average of up to 4 hours of care per resident per day over the next four years."²³⁹

Since this could not be achieved without more staffing, Ms. Sharkey also recommended to "...develop strategies to increase recruitment and retention of health providers, including physicians, nurse practitioners, nurses, PSWs, and allied health professionals to the long-term care home sector."²⁴⁰

Ms. Sharkey's report, like the ones before it, sat on a shelf collecting dust.

It was, however, referenced in a later report conducted by a Long-Term Care Task Force on Resident Care and Safety chaired by Gail Donner, former Dean of the Faculty of Nursing at the University of Toronto. This report identified 18 action items to improve the safety of residents, including a call to implement the Sharkey report:

"Recognising that there are not enough direct-care staff to meet the needs of all long-term care residents safely, the Long-Term Care Task Force on Resident Care and Safety strongly recommends that the Ministry of Health and Long-Term Care implement the recommendations of the Sharkey report on strengthening staff capacity for better care..."²⁴¹

It would take 13 years from the time of the Sharkey Report for an almost identical recommendation to be reissued in the province's 2020 Long-Term Care Staffing Study, and it was the result of yet another tragedy in long-term care.

From 2017 to 2019, Justice Eileen Gillese held a public inquiry into the safety and security of residents in long-term care following the murder of several residents by Elizabeth Wettlaufer. Like prior inquests, such as the one at Casa Verde, the purpose was to inquire into not only the crimes but also the factors that allowed them to be committed.

Justice Gillese's recommendations repeated the need to increase the number of registered staff in long-term care homes. It was recommended that the MOHLTC "should conduct a study to determine adequate levels of registered staff in long-term care (LTC) homes on each of the day, evening and night shifts. The Minister of Health and Long-Term Care should table the study in the legislature by July 31, 2020. If the study shows that additional staffing is required for resident safety, LTC homes should receive a higher level of funding overall, with the additional funds to be placed in the nursing and personal care envelope."²⁴²

Long-Term Care Staffing Study, July 2020

The staffing study recommended by the Gillese Inquiry was completed in July 2020 and made recommendations in five key areas, including staffing.

The staffing challenges were underlined by expert participants consulted for the staffing study:

"Due to these outbreaks and other COVID-19 related issues, the sector peaked at 38 homes reporting critical staffing shortages. The largest proportion of missing shifts were among PSWs, with one home reporting as many as 60 vacant PSW shifts experienced daily. Shortages existed in other staffing categories as well. For instance, one 128 bed home reported 10 registered nurses missing per day."²⁴³

The staffing study recommended that "the number of staff working in long-term care needs to increase and more funding will be required to reach that goal... This includes a minimum daily average of four hours of direct care per resident."²⁴⁴

The government responded to this study in a report released five months later and nine months after the start of the pandemic, in December 2020, identifying as its first priority the need to

"...increase the average amount of direct hands-on care provided by registered nurses, registered practical nurses and personal support workers to four hours a day per resident, with an increased focus on nursing care."²⁴⁵

However, there was a catch. The implementation of this goal was to take place over four years from 2021 to 2025.

It is disconcerting that the implementation of Ontario's staffing solution would not start while it is urgently needed during COVID-19.

Despite the findings of its own study, and many media reports highlighting staffing issues, once again, Ontario has lagged between other provinces in addressing long-term care staffing issues on an urgent basis:

“While provinces such as B.C. and Quebec launched ambitious recruitment drives to hire thousands of additional long-term-care workers last year, Ontario’s plan to train and hire more workers has a 10-year timeline. Ontario also pledged to spend ‘up to’ \$1.9 billion annually by 2024-25 to create some 27,000 ‘full-time equivalent’ jobs in the sector.”²⁴⁶

Of the lack of action on the recommendations of one of those 13 studies, the LTC Commission stated:

“The ministry’s Long-Term Care Staffing Study, released in July 2020, identifies the best path forward. Further ‘study’ of the Study is not necessary. What is required is the Study’s timely implementation.”²⁴⁷

As Beverly Mathers, CEO of the Ontario Nurses’ Association (ONA), has noted,

“So since at least 2001, numerous reports have been written confirming what staff who work in long-term care have known, that long-term care is grossly inadequate, their staffing, given the acuity and care needs of the residents, which has grown year over year.”

The staffing shortages are particularly acute for registered nurses, who comprise about 25 per cent of the more than 100,000 people who staff long-term care in Ontario.²⁴⁸

Demand for registered nurses has outpaced supply during COVID-19, continuing a problem that pre-dated the pandemic. As the province’s Long-Term Care Staffing Study noted:

“Prior to COVID-19, Ontario government analytics noted slow growth in Ontario’s registered nurse supply. Previous government modelling forecasted that the health system may have required more registered nurses to meet labour market demand and population needs.”²⁴⁹

In 2018, Ontario had the lowest per capita ratio of registered nurses in the country, at 690 registered nurses per 100,000 Ontarians. The Canadian average was 831. Newfoundland had the best ratio of 1,123 registered nurses per 100,000 residents, nearly double the Ontario ratio.²⁵⁰

“For Ontario to reach the average registered nurse staffing ratio in Canada, the province would need to hire 20,147 registered nurses,” observed Vicki McKenna, President of ONA, at the time this data was released in 2019.²⁵¹

This situation has been exacerbated by a trend that has seen fewer graduates remaining in nursing after a short period of time in practice, and more registered nurses retiring earlier than ever.

This crisis in staffing was not rectified when COVID-19 landed on the doorstep of nursing homes across Ontario.

Fuelling this shortage, are the challenges in attracting registered nurses to long-term care.

As Andre Picard, the dean of health care journalism in Canada, noted that

“...nurses are overworked and understaffed, forced to endure subpar pay, the instability of casual hours, gruelling mandatory overtime and the cancellation of holidays, all while putting their physical and mental health at risk. This is compounded by the fact that the field is dominated by women, who have been disproportionately saddled with child-care duties on top of their careers during the pandemic.

So the news that tens of thousands of nursing jobs are unfilled across Canada should come as no surprise. Nurses are fleeing hospitals, long-term care facilities, home-care agencies and public-health agencies – and who can blame them.

But what should surprise us even less is that, when the dust settles, it’s going to get a lot worse.

COVID-19 did not cause the nursing shortage, but the pandemic did supercharge the crisis. Demographics were and remain a factor... But the work environment is a much bigger problem.”²⁵²



Long-term care is so grossly understaffed and underfunded that our government should be ashamed of themselves! –ONA member, survey response

Working Conditions

The studies cited above repeatedly acknowledged that without sufficient staff and registered nurses, Ontario cannot meet the goal of increasing the level of care residents receive.

Study after study acknowledged the deep-rooted inequities in being employed in long-term care.

Several studies between 1999 and 2020 recognize the over-reliance on part-time positions and the need for full-time positions:

- A coroner's inquest into the influenza outbreak at Central Park Lodge heard that long-term care homes rely largely on part-time staff, who work in more than one facility and "could thereby risk serving as a vector spreading influenza" from one home to another. This is highly reminiscent of COVID-19 with many registered nurses being employed part-time at multiple facilities without full-time employment.²⁵³
- Ms. Smith noted that homes relied on part-time staff, resulting in a "casualization" of the work force, and recommended that more full-time staff were required. In addition, Ms. Smith recommended that strategic efforts are required "to promote the long-term care sector as a desirable career option, which has been a challenge due to staff shortages and pay inequities..."²⁵⁴

Other reports such as the Casa Verde inquest – held in 2001 after a resident murdered two fellow residents at a long-term care facility in Toronto – pointed to the lower pay of health care workers in the long-term care sector:

"In order to attract and retain sustainable Registered Nurses to provide the skilled continuity of care required, the MOHLTC should take immediate steps to enhance the working conditions in LTC facilities including...immediately change the funding system to ensure parity in wages and benefits with Ontario hospital Registered Nurses."²⁵⁵

The need to encourage recruitment efforts in long-term care by ensuring better paid positions was underscored in the 2020 provincial staffing study:

"Lack of wage and benefit parity across the care continuum can contribute to labour challenges, and

could be a possible deterrent, to working in long-term care."²⁵⁶

As a result, the study recommended that the Ministry of Long-Term Care take an "evidence-based, and systemic approach to compensation across health care settings and across occupations. Compensation parity should be strongly considered..."²⁵⁷

This recommendation has once again been ignored.

While the government in its Long-Term Care Staffing Plan recognized "...improving working conditions is integral to addressing issues of staff retention and improving the conditions of care for residents," there is not a single mention of improvements of wages.²⁵⁸

Rather, the government simply emphasized the need for 'sector-led' improvements:

"As the government makes significant investments to increase staffing levels, sector partners need to help lead change in critical areas. While the province recognizes the scheduling challenges of a 24/7 environment, this change must include exploring and sharing best practices to increase full-time positions, and employee retention."²⁵⁹

Without fundamental changes to the compensation to registered nurses and other health care workers, Ontario's seniors will not receive the level of care they deserve and that the province has promised to deliver.

The military found an untenable RN staffing ratio in one home:

"1 RN for up to 200 patients."²⁶⁰

The risk to residents of such a high ratio are well documented. As a study published in June 2020 concluded:

"Insufficient nursing staff can negatively impact all residents in a nursing home. Numerous studies of nursing homes reveal a strong positive relationship between the number of nursing home staff who provide direct care to residents on a daily basis and the quality of care and quality of life of residents."²⁶¹

Numerous studies have found that higher registered nurse staffing levels and care hours are associated with such better resident outcomes as fewer pressure ulcers; fewer catheterizations; decreased urinary tract infections; less weight loss and dehydration; lower use of physical restraints; less improper and overuse of antipsychotics; less hospitalizations; increased resident satisfaction; and lower mortality rates.²⁶²

Even before COVID-19, working conditions in long-term care were considered dangerous, a factor that may have contributed to making it a less attractive workplace.

Ontario's Long-Term Staffing Study found that:

"The health care sector ranks second highest for injuries resulting in time lost in Ontario, and long-term care workers are among the most at risk for physical injury within the sector. As of 2015, the Workplace Safety and Insurance Board reported 3,822 injuries among the long-term care workforce which did not result in the worker needing time off, and 1,747 which did require time off. These injuries represent 27 per cent of total injuries resulting in time lost in the health care sector. The most common reasons for injuries requiring leave were musculoskeletal disorders (38 per cent), exposure to contaminants or chemicals (31 per cent), slips, trips, and falls (11 per cent), and workplace violence (9 per cent)."²⁶³

For-Profit vs. Non-Profit

COVID-19 has also raised troubling questions about the quality of care in the province's for-profit long-term care facilities.

About 58 per cent of Ontario's nursing homes are privately owned. Non-profits or charities operate 24 per cent of nursing homes while municipalities run 16 per cent.

The Ontario COVID-19 Science Advisory Table observed poorer outcomes in for-profit long-term care facilities:

"Homes with for-profit status had outbreaks with nearly twice as many residents infected...and 78% more resident deaths...compared with non-profit homes."²⁶⁴

The Ontario COVID-19 Science Advisory Table also noted that residents of for-profit homes receive, on average, a mere 2.7 hours of care per day.²⁶⁵

Tamara Daly, professor of health policy at York University in Toronto, said, "I think the money would be more appropriately spent on hiring permanent, full-time staff, paying higher wages and benefits, and improving overall quality of life for residents."²⁶⁶

Indeed, while staffing and other problems intensified in long-term care, the three largest for-profit nursing home operators in Ontario paid out \$1.5 billion in dividends to shareholders over the last decade, the *Toronto Star* reported. This total did not include \$138 million paid in executive compensation and \$20 million in stock buybacks (a technique that can boost share prices).²⁶⁷

Fast forward to COVID-19, in the first nine months of 2020, the same three for-profit long-term care operators in Ontario paid out nearly \$171 million to shareholders at the same time they received \$138.5 million in federal and provincial funding, the *Toronto Star* also reported.²⁶⁸

"Some of the money is going to go to for profits," said Pat Armstrong, a professor at York University, who is leading a global study of nursing home standards. "In order to get the profits, they have to cut back in some areas."²⁶⁹

Global institutional investors are evidently reviewing their portfolios and considering divesting from major for-profit Ontario long-term care operators.

The *Toronto Star* reported that at least two major pensions funds,

"...including the Canada Pension Plan, have divested millions from the companies since the pandemic began, selling at a loss. The moves highlight ethical questions for seniors whose livelihoods rely on dividends from companies accused of scrimping on seniors in their care..."²⁷⁰

Richard Leblanc, a professor of corporate governance at Harvard and York universities, says COVID-19 has exposed problems with for-profit nursing homes and this has worried investors.

"LTC homes are a very good example of what happens when you put profits ahead of people," Leblanc said.²⁷¹

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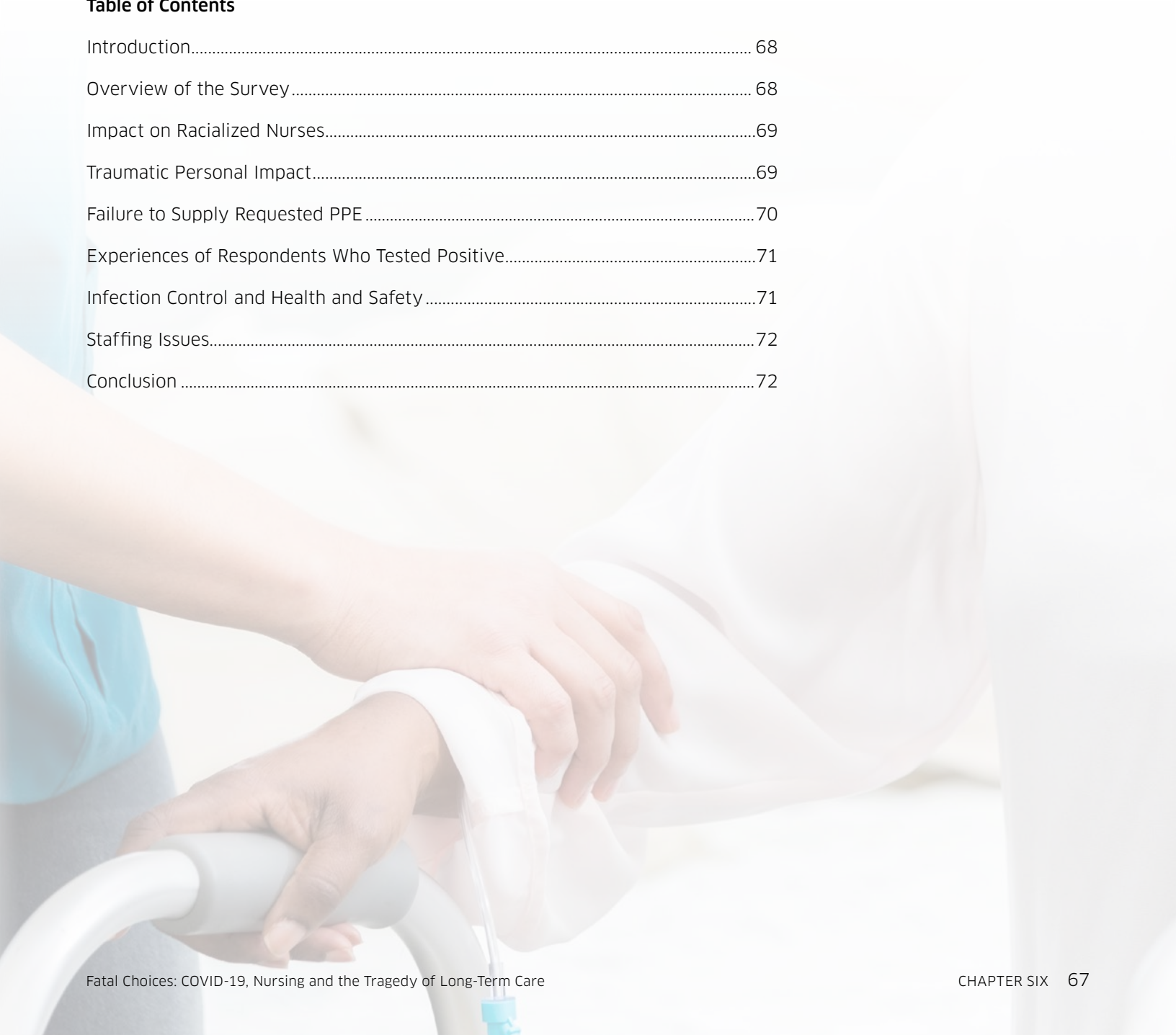
Chapter 6

Survey of Registered Nurses in Long-Term Care

6

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Introduction:

“I have never felt more helpless. There were too many residents dying, and I couldn’t help them all. There was also the knowledge of knowing I would catch COVID because of the non-existent PPE, but continuing to work because, if I didn’t stay, there would be no staff.”

The gut-wrenching experience of one registered nurse was emblematic of responses to an Ontario Nurses’ Association (ONA) survey of its members in long-term care in the fall of 2020.

“I am normally very positive,” said another respondent, *“but I found myself scared for my life going to work every day in a facility that we knew had a confirmed outbreak. I was scared that I might bring COVID home to my family.”*

For another respondent, the worst part was, *“watching the residents physically decline was terrible, having two of the PSWs that I worked with die was horrific, having the RN who I was replacing forced to work on the unit when I tested positive and her ending up on a respirator in ICU. I don’t even have the words!”*

A persistent finding of the survey was the widespread failure of employers to listen to, and act upon, the concerns and recommendations of registered nurses.

Nearly half of respondents (49 per cent) had raised concerns about COVID-19 to management or the joint health and safety committee (JHSC), a vital element of Ontario’s workplace safety regime that is supposed to bring together employers and workers to collaboratively address workplace hazards.²⁷²

“Requested the JHSC meet more frequently, which was refused,” recalled one respondent.

Added a second: *“I told management and health and safety about my concerns, but they continued.”*

A third respondent said:

“I suggested to management that we should start screening and offer masks to staff. I was denied and was told, ‘We are not going to be crazy! We don’t have enough supplies.’ I asked my coworkers to put a mask on when on duty with our own masks. Management denied. We were not allowed to use any masks on the floor until the end of March.

When 112 countries had positive cases, all of the staff who came from outside Canada had to come to work immediately after vacation. This is not safe practice. I suggested those staff should self-isolate at home for two weeks. Management denied. They said, ‘We don’t have enough staff. We are already short.’”

ONA undertook a similar survey following SARS. Justice Campbell wrote in his final report that it was a very important source of information:

“Nurses who responded to the ONA questionnaire provided a rich source of information on the experience of Ontario’s nurses during the SARS outbreak. They provide compelling observations on what went right during the SARS outbreak, what went wrong, what lessons we should learn. They give us a picture of the dangerous and frightening work of nurses on the front lines. The depth, scope and quality of the responses of these nurses give us a strong and candid insight into what actually happened.”²⁷³

Seventeen years later, ONA’s COVID-19 survey provides equally insightful quantitative and qualitative insights into the experiences of registered nurses in long-term care during the pandemic.

Overview of the Survey

Between September 12, 2020 and October 4, 2020, a total of 766 ONA members completed the survey.

Survey respondents had significant direct experience with COVID-19 outbreaks: 50 per cent had gone through an outbreak.



Managers have been going on holidays all summer and having weekends off while we work completely short-staffed... –ONA member, survey response

With regards to the profile of the respondents:

- 90 per cent of respondents identified as female.
- 86 per cent said long-term care was their primary sector of work.
- The highest proportion of responses came from the Greater Toronto Area (263).
- 58 per cent of respondents worked in the for-profit sector while 52 per cent worked in the not-for-profit sector (defined as including charitable and municipal homes).
- 62 per cent of respondents reported having full-time employment while 28 per cent reported being part-time.
- 48 per cent of respondents worked at their primary place of employment for five years or less.

Impact on Racialized Nurses

Among respondents, 35 per cent identified themselves as racialized. The largest populations of racialized respondents self-identified as South Asian (9.78 per cent), Black (8.3 per cent), and Filipino (8.2 per cent). Two per cent of respondents identified as First Nations (including status and non-status) and two per cent as Métis.

Among respondents who worked at a long-term care home during an outbreak, 63 per cent identified as racialized. Racialized respondents were more likely to work in an outbreak home with 11 resident infections or greater (53 per cent) compared to non-racialized respondents (20 per cent).

The survey suggested employment inequities for racialized workers who, more often than non-racialized workers, wanted but were unable to secure full-time jobs. Sixty-one per cent of racialized respondents expressed a desire for full-time work, while 27 per cent of non-racialized desired full-time. About one in four (26 per cent) of racialized respondents said they were employed at more than one home, compared to only nine per cent of non-racialized respondents.

Outbreaks involving more than 70 residents were more likely to take place in for-profit homes (13 per cent) compared to not-for profit (three per cent). Not-for-profit were more likely to have outbreaks containing five or fewer residents (63 per cent) compared to for-profit (50 per cent).

Traumatic Personal Impact

Fifty-one per cent of respondents reported experiencing a symptom of post-traumatic stress disorder (PTSD), including depression, anxiety, sleeplessness, or nightmares.²⁷⁴ For registered nurses who experienced a large outbreak, this percentage jumped to 61 per cent.

“Never worked under circumstances like this,” said one registered nurse. *“It felt like a terrible nightmare. We started the day with a prayer for all of us. Never knew if we are going to finish the shift and how many of us will be still alive.”*

She added:

“Our second family/residents were dying from this terrible virus in large numbers. Never seen this many people dying. There were and still are horrible nightmares and sleepless nights and death all around. Nobody seemed to care or willing to help. We were counted as collateral damage, dismissed easily as we don’t really count in an outbreak. Have not seen my family for months, put my husband who understood and supported me under the same pressure.”

The 2003 ONA survey had a similar finding of trauma in SARS’s worst affected settings. Respondents who worked at North York General Hospital and The Scarborough Hospital had the highest levels of post-traumatic stress: 57.1 per cent and 47.0 per cent respectively. They were the two hardest-hit health care facilities during SARS.²⁷⁵

Nursing was already recognized as a highly stressful profession in pre-pandemic research:

- Before COVID-19, experts estimated that as many as 28 per cent of nurses experience PTSD at some point in their careers.²⁷⁶
- Moreover, a pre-pandemic survey of nurses – published in the *Canadian Medical Association Journal* – found members of the profession were already experiencing high levels of stress even before COVID-19. Nearly 78 per cent of nurses who responded to the survey reported feeling a sense of burnout in the previous month.²⁷⁷

Yet, despite the terrible stressors of COVID-19 and the pressures inherent in the profession, the ONA COVID-19 survey found that four in 10 respondents worked for employers that did not offer employment assistance programs.

It is disappointing that so many registered nurses in the highly traumatic environment of long-term care during COVID-19 don't have access to support programs.

Instead, respondents had to rely solely on colleagues and family for support. One respondent said:

“People at work understood, family members were calling and supporting us in the fight and praying for all of us. Impact of COVID-19 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.”

Other survey findings regarding the personal experiences of nurses:

- Some 34 per cent of respondents who work in for-profit homes, and 25 per cent who are in the not-for-profit sector, said they were not satisfied with the leadership in their place of work.
- Some 47 per cent of respondents said their experience during COVID-19 had changed their attitude towards nursing, while 45 per cent said that COVID-19 changed their attitude towards long-term care.
- About one in five (21 per cent) reported losing income as a result of being quarantined or isolated.

Failure to Supply Requested PPE

Some of the survey's most troubling findings involve the large number of respondents who reported that employers interfered with their right to use a Point of Care Risk Assessment (PCRA) to decide whether an N95 respirator was required.

“I asked for PPE for myself and staff but was denied,” said one respondent. *“I was publicly shamed in front of my peers for wearing a face mask.”*

“When I requested an N95, I was told that a surgical mask is good to go,” said a second respondent.

Another registered nurse said:

“They were giving us one surgical mask for four days at the beginning and insisted we would not need N95 masks because guidelines were for droplet precautions and that we had no aerosolizing procedures.”

I insisted that if we were to have presumed or positive cases – that we would need better protection such as N95s and goggles. They insisted that surgical masks would be sufficient.”

Nearly one-third (29 per cent) of respondents said a manager interfered with their PCRA and told them that they did not need an N95 respirator. Significantly, this was most likely to have occurred in homes with a medium/large outbreak (45 per cent).

One respondent recalled: *“The administrator did not feel that all PPE was required when I had assessed that I wanted to wear the N95, goggles and face shield knowing the residents I was going to assess had a history of being resistive, at times spit, etc.”*

Respondents working in a home with an outbreak were more likely to provide care to residents who were coughing, sneezing and spitting without an N95 (35 per cent) compared to those who did not work during an outbreak (24 per cent).

About one in four (24 per cent) respondents said they were denied an N95. Respondents with a medium/large outbreak were the most likely to be denied an N95 (37 per cent).

Respondents working in a home with a medium/large outbreak were more likely to be denied an N95 (37 per cent) than those who worked during a small outbreak (25 per cent) or experienced no outbreak (20 per cent).

This finding is illustrated by the experiences of the following respondents:

“The managers kept the N95s in their office and did not give us any to wear. They said they were not needed.”

“Management insisted that [N95s] are not necessary as COVID-19 is droplet.”

“Long-term care consultant said I didn't need it [an N95].”

“Whenever staff asked for them [N95s], they were told/we were told that a surgical mask would provide the same protection.”

“[Told] the regular surgical masks were sufficient.”

Many nursing homes failed to ensure any supply of N95 respirators. About half of respondents (49 per cent) said their home had no N95 respirators for a brief time.

For-profit homes and homes in outbreaks with greater than five residents were more likely to experience supply issues with personal protect equipment:

No supply for three days or more	Not-for-profit (per cent)	For-profit (per cent)	Outbreak: 5 or fewer residents (per cent)	Outbreak: More than 5 residents (per cent)
N95 in correct size	20	28	21	43
Gloves	2	2	1	4
Gowns	10	13	7	16
Goggles	15	18	7	27
Face shields	18	20	15	30
Surgical masks	10	9	10	11

Experiences of Respondents Who Tested Positive

Of the total number of respondents, six per cent tested positive for COVID-19.

In a reflection of a troubled work environment where public health guidelines were frequently not followed, 15 per cent of respondents who tested positive said they were required to return to work while still exhibiting symptoms.

More than one in five respondents (22 per cent) who tested positive were required to return to work before the standard two-week quarantine period had elapsed.

Of respondents who tested positive:

- About one in four (26 per cent) continued to experience symptoms after their recovery.
- 82 per cent believed they were exposed to the virus at work.
- 85 per cent worked at a for-profit home.
- 97 per cent experienced a medium or large outbreak.
- 82 per cent returned to work after their recovery.

Infection Control and Health and Safety

Homes with a large outbreak were less likely to have an Infection Prevention and Control program (15 per cent) than those with small outbreaks (five per cent) or no outbreaks (eight per cent).

More than half (51 per cent) of nurses redeployed to long-term care facilities witnessed the failure to comply with guidelines and best practices of infection prevention and control (IPAC) standards.

Of respondents who had been re-deployed to a long-term care facility, 39 per cent said they were not satisfied with IPAC practices at their new facility, while 51 per cent said they witnessed a violation of the IPAC best practices.

As one nurse explained:

“I was extremely concerned that there was no cohorting/grouping of COVID positive/negative residents. They were sharing rooms and sharing a bathroom. Staff were not grouped and the same staff were caring for both positive and negative patients.”

Throughout COVID-19, registered nurses had the knowledge and expertise to protect residents and health care workers, but were not given the tools to do so.

Referring to *“PSWs yelling at me on a daily basis because there were insufficient PPEs and PSWs,”* one registered nurse said: *“I had no power and all the accountability.”*

Registered nurses played a pivotal role in preventing the spread of COVID-19 in homes:

“Truly saw how poor management is,” said one registered nurse. *“If the staff RNs did not take control, the virus would have spread in this home. For-profit home only cares about money in their pocket.”*

Nearly one-third of respondents (31 per cent) reported they felt inadequately protected because management took no measures, insufficient measures or measures were implemented too late.

Some 65 per cent of respondents had received infection prevention and control training within the previous six months, while 23 per cent of respondents said they received training within the last year, eight per cent said they received training over one year ago and five per cent said they never received training.

Of those who received training, less than half (47 per cent) said it met their needs. About one-third of respondents (34 per cent) said their training consisted of being given a document to review. Only one in five (21 per cent) received in-person, hands-on training.

Training focused on COVID-19 did not appear to have been consistently deployed across the sector. About one in four (27 per cent) said their employer did not conduct training sessions or hold meetings to address COVID-19 hazards, new developments, and measures and procedures in place for health and safety.

Respondents reported failure of core infection control practices. Nearly four in 10 (38 per cent) who worked during an outbreak were required to wear the same mask when treating both sick and healthy residents.

Staffing Issues

Staffing issues were a constant during COVID-19, according to survey respondents.

“We were barely able to run with staffing shortages and extra steps needed for isolation, and screening duties,” said one respondent. *“Staff floated all over the home. No cohorting.”*

The survey found:

- Half of the respondents (50 per cent) reported that staffing levels decreased during the first wave.
- Approximately one-third of respondents stated that both registered nurses (32 per cent) and registered practical nurses (31 per cent) were short-staffed several times a week.
- Two-thirds of respondents (67 per cent) reported that personal support workers were short-staffed several times a week.
- More than one-quarter (27 per cent) stated that their home relied on temporary or agency staff.

“Lack of staffing meant residents on isolation didn’t have dedicated workers,” said one respondent.

About one-third (36 per cent) of respondents who were redeployed to a long-term care facility reported not receiving training in advance. Less than half (47 per cent) said the information and training they received in advance of redeployment was sufficient.

Conclusion

The data collected in the ONA COVID-19 survey provides a rich source of information representative of registered nurses’ experiences during the first wave.

The recorded observations offer a wealth of knowledge of what needs to be addressed moving forward.

On a whole, the survey results show that the unsafe conditions in long-term care was not isolated to simply one or two workplaces. They demonstrate a broader systemic failure province-wide across the sector.

To give more context to the survey results, the following chapter will examine two long-term care homes that experienced deadly outbreaks during the first wave.

These accounts provide insight into the struggles of registered nurses and the difficulties that were encountered to make their workplaces safer for them and their residents.

It was no small challenge.

References

272. The Canadian Centre for Occupational Health and Safety states: "A joint health and safety committee is a forum for bringing the internal responsibility system into practice. The committee consists of labour and management representatives who meet on a regular basis to deal with health and safety issues. The advantage of a joint committee is that the in-depth practical knowledge of specific tasks (labour) is brought together with the larger overview of company policies, and procedures (management). Another significant benefit is the enhancement of cooperation among all parts of the work force toward solving health and safety problems." <https://www.ccohs.ca/oshanswers/hsprograms/hscommittees/whatisa.html>
273. SARS Commission Final Report, Volume 3, December 2006, p. 967.
274. The ONA COVID-19 survey asked the specific question: "Have you suffered symptoms of post-traumatic stress as a result of the COVID-19 outbreak? (i.e., depression, anxiety, sleeplessness, fear, nightmares, etc.)". The Mayo Clinic defines post-traumatic stress disorder as a "mental health condition that's triggered by a terrifying event – either experiencing it or witnessing it" at <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>
275. SARS Commission Final Report, Volume 3, December 2006, p. 967.
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7

Chapter 7

Case Studies – Anson Place and Madonna Care

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Introduction:

To fully grasp the tragedy of COVID-19 in long-term care, let's examine how this new pathogen was introduced and spread in two hard hit facilities.

The evidence shows that too little was done to protect the residents of Anson Place Care Centre (Anson Place) near Hamilton, and Madonna Care Community (Madonna Care) in Orleans, just east of Ottawa.

Far too often, the timely warnings and recommendations of registered nurses – measures that could have saved lives – were discarded, disrespected, and disavowed.

COVID-19 infected 73 of its 101 residents and 31 staff at Anson Place, resulting in the death of 27 residents.

A registered nurse at Anson Place described conditions there that left her “horrified and frightened:”

“The elderly residents cannot withstand the COVID-19 virus. The residents in our long-term care unit are very frail and have complex health issues, including dementia and numerous co-physical problems and limitations.

...the Town of Haldimand arranged to have paramedical students in to help provide food and water to the residents. The residents will face dehydration and do not have the necessary care.

We do not have enough nursing staff to provide the appropriate care per shift even in so-called regular times, let alone when there is a highly infectious disease like COVID-19 spreading on the unit.”

According to an in-depth investigation by *The Globe and Mail*, there were many missed opportunities to protect residents and staff at Anson Place:

“...the outbreak resulted from failings at every level in the system designed to protect the frail elderly. The home, doctors at the local hospital, public health officials, provincial safety inspectors, and Ontario's top medical officer all missed early opportunities to prevent the spread of the virus.

Everyone from the management of the home to the Premier's Office was slow to respond to cries for

help from front-line health care workers, who were forced to ask both an Ontario Superior Court Judge and the province's quasi-judicial Labour Relations Board to intervene.

It was only on April 21 – nearly a month after the first outbreak at a nursing home in Ontario – that chief medical officer of health David Williams ordered local public health units to test everyone in long-term care homes for COVID-19, the respiratory disease caused by the novel coronavirus.”²⁷⁸

At Madonna Care, COVID-19 took the lives of 47 residents and two staff members during its first outbreak, which began on April 15, 2020, and ended on June 8. It would experience three other outbreaks between June and October 2020.²⁷⁹

“The minute you walked in the door to the resident area, it hit you,” said a registered nurse who volunteered to assist at Madonna Care in May at the height of the first outbreak. *“The lack of staffing; you had pharmacy technicians doing patient care; first year paramedic students with no practical training...orientation, from the one manager there, was ‘here's a mask, here's your floor, and that's orientation.”*²⁸⁰

Despite contracting COVID-19 herself, the registered nurse said: *“Would I go back? Sure I would. These are the people that fought wars for us.”*²⁸¹

This chapter is based on interviews and declarations by registered nurses, media reports, legal proceedings, and correspondence with Anson Place and Madonna Care management.

Anson Place

Overview

A retirement home and long-term care facility operated by the for-profit Rykka group, Anson Place occupies a two-storey building, with a 40-bed retirement home on the first floor, and a 61-bed long-term care unit on the second floor.

The building is divided into two wings, west and east.

The long-term care facility has a mix of seven four-bed basic ward rooms; 15 two-bed semi-private rooms; and three single-bed private rooms. All of the beds are built to 1972 design standards.

The ward rooms are partially divided by ceiling-to-floor walls that extend eight feet from the window into the room. There are two beds on either side of the partial wall, with a curtain that can be drawn for privacy. All four residents in a ward room share a bathroom.

The semi-private rooms have two beds separated by a curtain. The residents share a bathroom. To say it is close quarters would not be an understatement.

The home also has a central entrance and lobby where residents of both the retirement home and long-term care home intermingle. There is an elevator in the main lobby, which is also used by all. There is an additional entrance in the basement and entrances at the ends of the two wings with stairs between the basement, first and second floors.

The Events of March 18, 2020

On the evening of March 18, 2020, a registered nurse at Anson Place said she received a phone call from the Haldimand-Norfolk Health Unit, indicating that an animal entertainer who had performed there on March 6 had tested positive for COVID-19.

While authorities would never officially confirm whether the animal entertainer was the source of the outbreak, COVID-19 quickly spread among the residents in the retirement home and then to residents in the long-term care home.

The outbreak, which lasted from March 27, 2020 to June 25, 2020, had devastating consequences: more than two-thirds of the resident population and 31 staff would become infected.

Tragically, 27 residents would die.

“The worst part was losing so many.” said one registered nurse at Anson Place, adding, *“The most disturbing point was they were passing so quickly and without family. We had PSWs and registered staff who would just take a few minutes to sit with someone.”*

Anson Place’s response to the March 18 telephone call set the tone for a pandemic response that lacked urgency and transparency.

Following the March 18 call from Public Health, the first floor of Anson Place was locked down for three days, according to media reports.²⁸²

Interviews indicated that management never told staff on the second floor the reason for the lockdown. On top of this, personal protective equipment was not provided to second floor staff until more than a week later.

An anonymous staff member who spoke with *The Globe and Mail* was quoted as being told by management, “Don’t worry, it’s [the lockdown] not COVID related.”²⁸³

A registered nurse who arrived at work the next day – on March 19 – said she was not told by management that the first floor was in lockdown. She stated:

“At no time was I advised of the nature or state of the infectious disease on the main floor. I was advised by the staff from long-term care who went out for a smoke and spoke to the staff working on the retirement residence as they put out the garbage in full PPE.”

One registered nurse said any time COVID-19 concerns were raised with management, they appeared to not want to discuss it.

Staffing Issues Mount

Widespread testing in the facility did not begin until March 29-30, 2020. In the meantime, the virus spread quickly. One day earlier, on March 28, a male resident who would eventually test positive developed a fever on the second floor. That same day, a registered nurse who had been swabbed on March 26 was confirmed positive.

As the outbreak progressed, residents and staff became infected at alarming rates. Staffing levels were decimated by COVID-19.

At the height of the outbreak, only two registered staff and two or three personal support workers remained negative and were able to work. Eight-hour shifts were extended to 12 to 16 hours. Registered nurses hired as casuals worked more than full-time hours. The activity coordinator and housekeeping staff performed the work of personal support workers.

The province offered to assist. However, despite these staffing issues, the *Toronto Star* reported that the Executive Director declined the offer.²⁸⁴

One staff member said: *“We would have appreciated the help. We had the bare minimum of staff.”*

Registered nurses at Anson Place said they felt abandoned. One recalled:

“From March 18, management had refused to tell us anything about the COVID-19 status in the building and had not informed us about any precautions we should take on the long-term care unit.”

Staff that were interviewed stated that senior management of the home were absent leading up to the first weeks of the outbreak. One registered nurse recalls that the Director of Care was not on-site, unavailable, and staff were specifically instructed not to call her.

Anson Place was also not meeting its legal duty to advise the Ontario Nurses' Association (ONA) of workplace exposures.

The requests from the acting bargaining unit president for information of exposed staff members went unanswered.

Ministry of Labour Inspections

ONA's acting bargaining unit president filed two complaints with the Ministry of Labour against Anson Place following the declaration of the outbreak.

The first complaint on March 30 arose from the employer failing to respond to requests for information about who in the workplace was exposed.

The Ministry of Labour inspector refused to include the complainant in the investigation. Instead, the employer selected the worker representative who would

participate. The inspector reviewed the employer's swabbing protocol and personal protective equipment. No orders were issued.

ONA's second complaint was filed on April 6 and 7 alleging the employer was failing to take reasonable precautions to protect workers and failing to provide notice of occupational illness. The inspector issued a field visit report that stated the employer was in violation of the *Occupational Health and Safety Act* and that action was required to make sure N95s were available outside of regular work hours.

Despite these findings, no orders were issued.

Neither inspection took place in person. Anson Place's inspections, like most other inspections at that time, was done over the phone.²⁸⁵ This was problematic as the inspector was unable to witness the workplace hazards that led the workers to become sick.

Three weeks later on April 27, a total of nine orders would be issued against Anson Place after a legal settlement required an inspector to attend the facility in-person. However this was too little, too late.

Grievance and Injunction

After ONA noticed a troubling pattern of the Ministry of Labour not issuing orders against employers, ONA filed a grievance on April 7, which stated that Anson Place was,

“...failing to take adequate measures to ensure the safety of Registered Nurses, failing to provide adequate personal protective equipment, failing to follow the precautionary principle, and failing to take every precaution reasonable in the circumstances arising as a result of the extraordinary threat posed by the COVID-19 pandemic.”

ONA wrote to the employer asking that the grievance be heard by an arbitrator on an urgent basis. The employer's representative responded to ONA the same day saying there was a problem and denied the request.

Given the urgency of the circumstances, ONA took the extraordinary step of filing an application for injunctive relief with the Ontario Superior Court of Justice against Anson Place and three other long-term care homes.

The application was filed on April 16 and was heard by the Court on April 22. Justice Edward Morgan released his decision on April 23 in favour of ONA. More will be said later in this chapter on the Morgan decision.



You can't look after a full wing, do a med pass with proper donning and doffing, answer every phone call and be the screener. –ONA member, interview with ONA counsel

Failure to Cohort

COVID-19 in Anson Place demonstrated the tragic consequences when public health and employers fail to listen to the clinical judgment of registered nurses.

It also demonstrated that, in Ontario during COVID-19, ONA and registered nurses had no other recourse but to go to court to force long-term care facilities to follow public health guidelines and protect both residents and staff.

They were forced to take on an enforcement role that Ontario had abdicated.

When the outbreak was declared on the long-term care floor on March 27, all residents were confined to their rooms. But there appears to have been no effort to separate residents who tested positive from others, a practice known as cohorting.

Instead, positive residents in ward rooms or semi-private rooms remained with their roommates, even if their roommates were negative.

One of the fundamental principles of controlling a respiratory infectious disease outbreak in a long-term care facility is to isolate confirmed and suspected cases to be alone in a room, or if that is not possible, grouping contagious residents together, so they don't infect other residents or staff.

Directive #3 for Long-Term Care Homes issued by the Chief Medical Officer of Health provided mandatory measures to be followed, including cohorting:

“Staff and Resident Cohorting. Long-term care homes must use staff and resident cohorting to prevent the spread of COVID-19. Resident cohorting may include one or more of the following: alternative accommodation in the home to maintain physical distancing of 2 metres, resident cohorting of the well and unwell, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate. Staff cohorting may include: designating staff to work with either ill residents or well residents.”²⁸⁶

The Centers for Disease Control and Prevention advises:

“Place patients with suspected or confirmed influenza in a private room or area. When a single patient room is not available, consultation with infection control personnel is recommended to assess the risks associated with other patient placement options (e.g., cohorting [i.e., grouping patients infected with the same infectious agents together to confine their care to one area and prevent contact with susceptible patients]...”²⁸⁷

The Public Health Agency of Canada offers similar advice:

“Patients suspected or confirmed to have influenza should be cared for in single rooms if possible. Perform a risk assessment to determine patient placement and/or suitability for cohorting when single rooms are limited or if in a LTC setting. Patients who are known to have influenza should be cohorted with suitable roommates.”²⁸⁸

Anson Place's own Infection Prevention and Control Manual follows this practice. It states that residents should be “segregated in specific areas in order to separate influenza and non-influenza residents to minimize spread of organisms.”

Staff, however, reported that no effort was made by Anson Place to cohort residents.

Between April 2 and April 6, ONA received many phone calls from its members at Anson Place, warning that Anson Place was still not cohorting residents or staff.

On April 7, management at Anson Place advised ONA that:

“Outbreak protocols are in place. All residents are isolated to their rooms and meals are being served to them.”

All residents were, indeed, isolated to their rooms but COVID-19 infectious patients were in the same room as healthy patients.

Furthermore, all but three of the home's residents had one or more roommates, which was not consistent with the public health directive on cohorting or Anson Place's own policies.

Frustrated by a lack of action that was endangering staff and residents, on April 9, 2020, ONA CEO Beverly Mathers wrote to Dr. Shanker Nesathurai, Haldimand-Norfolk Health Unit's Medical Officer of Health, detailing ONA's concerns about Anson Place, including its failure to isolate and cohort residents. A copy of the letter was sent to Anson Place.

Anson Place responded to the ONA letter, stating:

"In [ward rooms] a partition separates the room into two, having two residents on each side. We are protecting these two residents with a privacy curtain between these beds which will mitigate the spread of COVID-19."

Anson Place did not document the scientific basis for this assertion or indicate whether it was based on the advice of public health. Registered nurses understood a curtain would not stop the spread of COVID-19.

Dr. Nesathurai wrote a brief email to Ms. Mathers stating they are working with Anson Place to formulate "a public health management plan."

He simply referred ONA back to the letter from Anson Place, which confirmed that sick and healthy residents were in the same room, separated by a mere curtain.

ONA was not given any information as to whether the health unit had even attended the facility to determine whether they were in compliance with public health directives.

Since neither Anson Place nor local public health were acting to protect residents and staff, ONA was forced to go to court to seek an emergency injunction against Anson Place and three other long-term care facilities.

In his decision, rendered on April 23, Justice Edward Morgan noted that Anson Place

"...has also not even attempted to separate residents into segregated wards such that COVID-19 positive patients are not in the same room as those without the virus. Instead, it has opted to keep all residents in place and hang a privacy curtain between beds."

Justice Morgan granted an injunction requiring management at Anson Place and three other long-term care homes to follow Ministry of Health directives on cohorting and other infection control measures:

"The Respondents are further ordered to implement administrative controls such as isolating and cohorting of residents and staff during the COVID-19 crisis, as set out in Directives #3 and #5 issued by the CMOH [Chief Medical Officer of Health]. This order shall be in effect until a final disposition of the ONA's grievances against the Respondents in respect of these and related matters under their collective agreements, or until further Order of this court."

It is troubling that it took a court order to ensure that Anson Place followed its own policy – and provincial guidelines – to cohort.

Concluded *The Globe and Mail* investigation:

"Management at Anson Place did not follow its own pandemic plan, but instead kept residents made ill by COVID-19 alongside the healthy, causing the virus to spread."²⁸⁹

"*I am horrified by the situation at the Centre,*" said one registered nurse. "*I am filled with such a deep anger and sadness by the Centre management. There was no consideration and no precautions to protect the residents and staff, and now residents and staff are positive and sick.*" *The Globe and Mail* investigation also raised concerns about public pronouncements by the Haldimand-Norfolk Health Unit on the possible source of the outbreak.

Although the outbreak at Anson Place was officially declared on March 27, 2020, an investigation by *The Globe and Mail* suggests the first cases may have occurred much earlier. It reported that the first COVID-19 related death may have been a resident of the retirement home who died on March 16.

In the days leading to his death, he was evidently sent to hospital with difficulties breathing, lethargy and coughing. Not long afterwards, his entire family would test positive for COVID-19.²⁹⁰

The Haldimand-Norfolk Health Unit, however, on April 5 reported that the resident's funeral was the source of the Anson Place outbreak.

Both the family and the funeral home disputed those assertions by stating no one from Anson Place attended the funeral and no one from the funeral attended Anson Place.²⁹¹

When asked to clarify the situation, Dr. Nesathurai, the local Chief Medical Officer of Health, advised *The Globe and Mail* that they do not discuss matters involving individual community members and “assessments of this nature cannot be used to attribute blame to any individual.”²⁹²

Concluded *The Globe and Mail's* investigation:

“Public health erroneously blamed the outbreak at Anson Place on those who attended a former resident’s funeral, while not doing enough to help the home contain the spread of the virus.”²⁹³

Personal Protective Equipment

The Morgan decision also dealt with persistent problems with ensuring registered nurses and other staff had the right kind of personal protective equipment at their fingertips when they needed them.

His ruling identified a series of personal protective equipment problems at Anson Place. Registered nurses signed sworn statements that:

- Anson Place provided little or no access to N95 respirators, and discouraged or prohibited nurses from using N95s on the basis of their point-of-care risk assessment.
- Nurses were advised that N95s were unnecessary and would only be provided when a nurse was swabbing a patient for COVID-19.
- There were a number of instances where nurses wearing N95 respirators, as a result of their assessment that the patients under their care were actively contagious and posed a serious risk, were told to remove them and wear lesser protective surgical masks instead.
- Management at Anson Place kept a small supply of N95 respirators available at the nursing station for limited use while swabbing a patient. The rest of the home’s supply of N95s were removed from ordinary storage and placed under lock and key in the Executive Director’s office.
- The Director was prone to neglect replenishing N95 respirators for night staff, even the small supply of N95 respirators authorized for swabbing suspected COVID-19 patients.

In accepting this evidence, Justice Morgan ruled:

“The Respondents and their agents, employees, and those acting under their instruction are ordered to provide nurses working in their respective facilities with access to fitted N95 facial respirators and other appropriate PPE when assessed by a nurse at point-of-care to be appropriate and required, as set out in Directive #5 issued by the CMOH [Chief Medical Officer of Health]. This Order shall be in effect until a final disposition of the ONA’s grievances against the Respondents in respect of these and related matters under their collective agreements, or until further Order of this court.”

The ruling of Justice Morgan did not end ONA’s fight for health and safety protection of its members, residents and other staff.

The next example of Madonna Care reflects the extreme lengths some homes appeared to go to avoid following legal orders on health and safety.

Madonna Care Community

Introduction

Sienna Senior Living Inc., a for-profit corporation, operates Madonna Care, a 160-bed facility in Orleans, Ontario, near Ottawa. Built in 2007, it has only private and semi-private rooms.

Madonna Care announced its first outbreak on April 6, 2020. A resident who had a fever since approximately March 30 tested positive.

The virus spread rapidly in the home throughout March, April and May, infecting a total of 97 residents and 60 staff. Forty-seven residents and two personal support workers died.

The outbreak was finally declared over on June 8, 2020.

The story of COVID-19 Madonna Care is the story of how registered nurses and their union were again forced to continually fight for personal protective equipment and the challenges of labour arbitration to safeguard them in a timely manner. ONA went to the same Arbitrator three times before the facility finally demonstrated a sufficient N95 supply on November 3, 2020 – some eight months after the initial outbreak.



There is lack of nursing supplies or they are limited and staff is being reminded of budgetary restrictions regularly. –ONA member, survey response

The Introduction and Spread of COVID-19

At the end of March 2020, registered nurses became concerned when a resident began to exhibit a cough and a fever. This concern grew as the resident's condition worsened. Days later, he tested positive, confirming staff suspicions.

Yet, the evidence suggests that Madonna Care appeared to take little action to protect staff and residents:

- The roommate of the symptomatic resident was never moved out of their shared room by management and would soon be confirmed positive;
- The shared dining rooms were not closed until more residents became diagnosed. The table mate of the positive resident and his roommate quickly became infected; and
- A resident on the third floor of Madonna Care became infected, a sign that COVID-19 was spreading at an alarming rate.

Staffing Levels Decimated

Even before the outbreak, Madonna Care had struggled to retain staff and fill vacant registered nursing positions.

As the outbreak spread, this staffing crisis worsened to dangerous levels.

Registered nurses reported that during the outbreak, there were times when staffing was down to just one or two personal support workers to care for 32 residents in a 12-hour shift. In such situations, residents were not getting their care needs met.

In some cases, they were covered in urine and feces for hours – sometimes as long as six to eight hours – before someone was able to provide care.

This was heartbreaking for staff who wanted desperately to properly care for residents, but were unable to do so because of the dire staffing shortages.

A registered nurse who volunteered to assist at Madonna Care said:

“...the staff were not to blame for what happened at the privately-owned Madonna. They never received proper training. And for years personal care workers have sounded the alarm about conditions at long-term care homes across the province. But they were not seen by the wealthy owners and politicians as professionals to be taken seriously... Most are women, newer Canadians, and poorly paid. Their compassion was to be exploited.”²⁹⁴

When Madonna Care advised staff that they would have to choose one workplace, many declined to stay at Madonna Care because it did not offer full-time employment.

Most of Madonna Care's registered staff are part-time or casual. Many personal support workers chose to work elsewhere because Madonna moved from eight-hour shifts to 12-hour shifts. This also dramatically reduced the number of staff working at Madonna Care.

Poor Infection Control Practices

After the first COVID-19 case, Madonna Care implemented isolation protocols requiring residents be restricted to their rooms, whether private or semi-private.

While the policy was well intentioned, staff were not given the support or resources to enforce it. This meant, for example, that it was virtually impossible to ensure that residents on the second floor secure unit – where most residents are at advanced stages of dementia or suffer from other behaviour illnesses – remained isolated. Wandering was commonplace.

These difficult circumstances were documented in a June 2020 investigation by the CBC's *The Fifth Estate*. It broadcast an April 2020 video of four different residents entering, without permission or invitation, a female resident's room. The deeply troubling video – captured by a hidden camera installed by the female resident's concerned daughter – shows a male resident wandering into the female resident's room and coughing on her pillow and sheets, and eventually leaving. The resident's pillow and sheets were not changed the rest of that day.

Three days after that video was taken, the female resident contracted COVID-19. A second video shows several residents wandering into the female resident's room and sleeping in her bed after she was confirmed positive.²⁹⁵

There were simply too few staff to ensure residents remained isolated.

"We noticed right from the beginning they seem to be short-staffed," said the daughter of the female resident. "The PSWs and nurses seem to be run ragged."²⁹⁶

No action appears to have been taken to cohort residents until late into the outbreak.

In early May, a team from the Royal Ottawa Hospital inspected Madonna Care as part of the effort to provide additional staffing resources and expertise. The team witnessed patients "wandering around entire floors without masks" and "no cohorting in general."

Front-line staff were extremely concerned that cohorting had not been implemented. One registered nurse reported:

"I even received a call from angry family members who have stated the home is irresponsible for leaving a non-COVID resident in the same semi-private room as a COVID-positive resident. At the time of my last shift of work, I was aware of at least three circumstances, including the one noted above, where one resident in a semi-private room was diagnosed with COVID and the other was not. No efforts have been made to separate these residents."

The staff were not cohorted, either. The home required staff to work with both negative and positive residents.

Insufficient Personal Protective Equipment

Before COVID-19, N95 respirators were kept in a locked supply room. This proved highly problematic during Madonna Care's first outbreak, as evidenced by the registered nurse who looked after the first positive case at Madonna Care on the weekend of April 3, 2020.

After determining that she needed an N95 based on her clinical judgment, she was unable to find one on her unit. In such cases, she was supposed to contact the on-call manager. Unable to do so, she was let into the locked supply room by a maintenance staffer. This caused a two-hour delay.

At the time, staff were given just one surgical mask at the start of their shifts, and were told that N95s were not required when caring for positive COVID-19 residents.

On April 6, management of Madonna Care moved the N95s from the supply room to an undisclosed location, unknown to staff.

Staff eventually learned that all personal protective equipment, including all N95s, were locked away in the manager's office. This meant if staff needed an N95, and it was not already on the floor, they had to contact the on-call manager and be given a secret code to unlock the door to the manager's office. This procedure frustrated staff and delayed care for COVID-19 positive residents.

These issues came to a head on April 27, when a complaint from a health care worker prompted the Ministry of Labour to investigate.

The inspector – who did not attend at Madonna Care and held separate teleconferences with the employer and worker – appeared to take the employer's position at face value, submitting a report suggesting that:

- Workers had access to personal protective equipment;
- Staff who said they needed an N95 after a point-of-care assessment had no trouble getting one; and
- Madonna Care had not experienced any personal protective equipment shortages.

ONA received information indicating that these findings were not true.

In the face of the Ministry of Labour's failure to protect health care workers and residents, ONA organized a central arbitration process binding all 200 participating long-term care facilities to the decision of Arbitrator John Stout.

Arbitrator Stout sided with ONA, issuing a decision on May 4, requiring participating homes to have an appropriate supply of N95s and that nurses should be able to have ready access to N95 respirators when they needed them.

Madonna Care, however, did not readily comply with the order.

Enforcement

Following the Stout decision, ONA continued to hear complaints from members that N95s were not readily accessible at Madonna.

In response, on June 10, 2020, Arbitrator Stout issued another decision stating that Madonna had an insufficient supply of personal protective equipment. He ordered Madonna Care to demonstrate that they had enough supply of N95s should there potentially be another outbreak in the future.

On July 22, Arbitrator Stout ordered Madonna Care to produce records relating to fit-testing and supply of N95s from March to the date of the order. In his decision he stated, "I am not convinced that Madonna Care has complied with my June 10, 2020 award and that they have a sufficient supply of respirators."

When ONA complained about the quality of Madonna Care's records, Arbitrator Stout released another decision on July 31, in which he concurred, stating:

"I am not convinced that Madonna has complied with the orders in my awards as they relate to the supply of N95 respirators. The documents provided by Madonna are confusing and the information provided in them appears to constantly change. I do not trust the accuracy of the documentation and I agree with ONA that it is unreliable."

It was not until November 3, that ONA was satisfied that Madonna Care had obtained a sufficient supply of N95 respirators.

Conclusion

ONA pursued safety breaches in multiple legal arenas: labour arbitration, the Ministry of Labour, the local medical officer of health, and even the Courts to ensure that registered nurses, other health care workers, and residents were safe.

Even after orders were issued, ONA still had to monitor the situation closely and invoke legal proceedings repeatedly to ensure that the orders were being followed.

Unfortunately, the challenges with Madonna Care and Anson Place not following health and safety laws or legal orders were not limited to these homes.

ONA experienced ongoing challenges at many other long-term care facilities across the province.

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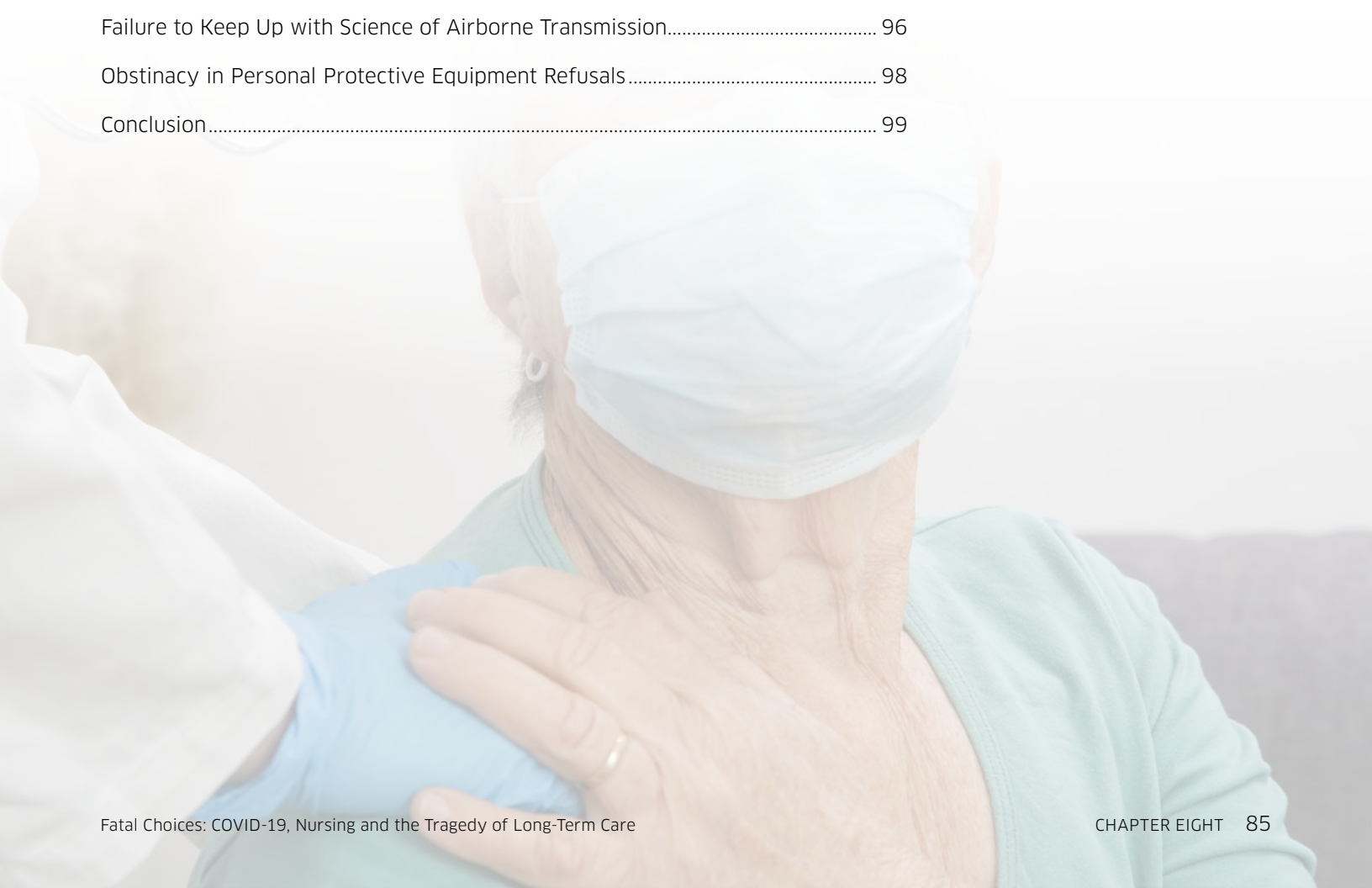
Chapter 8

Filling the Vacuum of Government Inaction

8

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Introduction:

If anyone doubted the importance and relevance of the labour movement in the 21st Century, COVID-19 should put those doubts to rest.

The pandemic has revealed a litany of failures by government and nursing homes in long-term care:

- The failure to prepare for a pandemic.
- The failure to follow the precautionary principle.
- The failure to safeguard against airborne transmission of COVID-19, as scientific confirmation mounted, and evidence of the shortcomings of a non-precautionary approach swelled.
- The failure to enforce occupational health and safety laws.

The list goes on and on.

At each step, as the pandemic unfolded and its toll in death and disease in long-term care worsened, the Ontario Nurses' Association (ONA) was forced to step in, address an emergency situation, and fill the void of government inaction by:

- Holding government, nursing homes, and public health accountable;
- Putting forward urgent solutions to protect residents and health care workers that were often rebuffed by nursing homes and continue to be resisted; and
- Ensuring that collective agreements, public health directives, and workplace safety laws were enforced in nursing homes.

It is highly troubling that a union has been forced to do what government and nursing homes are duty-bound, mandated, funded and expected to do.

As Dr. Eric Tucker, a professor at Osgoode Hall Law School in Toronto, asked:

“In what world is a court order needed to require employers to provide frontline health care workers with the personal protective equipment that they, in their professional judgment, relying on best practices and government directives, determine is needed to perform their jobs safely?”²⁹⁷

Enforcement Failures

During SARS, the Ontario Ministry of Labour was ineffective, largely sidelined, and didn't start pro-active inspections until June 2003, when the outbreak was virtually over.²⁹⁸

Seventeen years later, history repeated itself.

During COVID-19, the Ministry of Labour conducted 14,031 COVID-related inspections in the province between March 11, 2020 and July 13, 2020: 5,572 were by phone/email, and 8,441 were in-person. Of the field visits to health care facilities, the vast majority were reactive rather than proactive (1,305 vs. 457). The largest proportion of the complaints related to personal protective equipment, specifically N95 respirators.²⁹⁹

Despite the myriad of problems identified by registered nurses and unions in long-term care, the Ministry of Labour's COVID-19 inspections resulted in only 323 improvement orders in the health care sector.³⁰⁰

It has also issued just two fines in all workplaces it has inspected, and one was to a worker. Only one employer has faced any kind of financial penalty for breaking workplace safety laws, and none has faced prosecution.³⁰¹

A case in point was the Ministry of Labour's inspection of Altamont Care Community in Scarborough. The ONA Labour Relations Officer complained to an inspector that the nursing home failed to report occupational illnesses and critical injuries of health care workers who contracted COVID-19 in the workplace to the joint health and safety committee.

This was happening even though some staff had been hospitalized and one even died.

ONA was seeking important information to be shared about how health care workers had contracted COVID-19, notifying other workers who were exposed to COVID-19, and taking measures to prevent further spread of COVID-19 in the nursing home.

The inspector did not interview the Labour Relations Officer during this investigation and did not provide her with a copy of the Field Visit Report.³⁰² The inspector also failed to issue orders directing the employer to share information about workers' illnesses, so ONA was required to file an appeal to the Ontario Labour Relations Board.

“We should not have had to fight and continue to fight for PPE,” said one nurse. *“We were fighting a war to protect ourselves and the residents. Public Health and homes knew better and yet dug their heels in. Here we are in 2020, several viral threats in our past and I am embarrassed by the responses of our public health.”*

Part of the problem during SARS, according to Justice Campbell, was a deep-seated resistance in health care by “those in hospital administration and health bureaucracies who resist advice and enforcement on hospital turf by independent worker safety experts and the provincial Ministry of Labour.”³⁰³

Seventeen years after SARS, the status quo remains largely unchanged.

As occurred during SARS, the voices and critical assessments of health care workers, unions, occupational hygienists, worker safety experts, environmental engineers, and aerosol specialists are still largely missing when occupational health and safety decisions are made.

While labour unions have participated in consultative forums organized by the government, these appear to have been “tick-box” exercises intended to give the appearance of collaboration without any of the requisite substance.

“I am angry all the time,” said one nurse in long-term care.

“I read the whole [SARS Commission] report, but nothing was learned. It’s stunning. They went the opposite way. I am angry because I am watching in real time as they put everyone in harm’s way.”

The Struggle to Protect Nurses and Residents

The reality in long-term care in the midst of the second wave of COVID-19 is a stark one.

Consider that by the end of January 31, 2021, the *Toronto Star* reported:

*“An additional 34 residents of the province’s long-term care homes Wednesday have brought the province to a total of 3,029 deaths since the pandemic began.”*³⁰⁴

“Things deteriorated quickly” – The Experience of a Registered Nurse in Long-Term Care

“We were a broken record complaining about staffing every day. We cried every day, the personal support workers and I. We were yelling into a void that we needed staffing and no one is listening.”

When I came back to work, I was running around like a chicken with my head cut off.

Things deteriorated quickly. Residents were not eating or drinking. We ran out of IV poles and had to hang IV bags off coat hangers. Initially staff were not permitted to go to different floors but that became lax so they stopped cohorting staff so they could move them around because there was not enough staff.

There were shortages of staff all around. Lots of times I was doing the med pass and trying to do RN duties at the same time. Sometimes PSWs were working 12 to 16 hours shifts. One PSW did 20+ days without a day off. We had staff who had to leave in the middle of a shift because they got a call they were positive.

The local hospital would not send their staff to the COVID floor to help us. While there were staff educators in the home, they would only talk about the need for staffing ratios.

Residents on every floor got COVID, we also had a COVID unit on the 3rd floor. The 3rd floor had 21 residents die, one day four died and two in hospital. The vast majority of residents contracted COVID-19 with the death toll rising to more than 40.

During the second wave, after residents passed away, we had to bag the bodies, write their names, health card number and ‘COVID-19’ on the body bag, and roll the body down to the main entrance.

It was filthy. There was no housekeeping during the outbreak, very sporadic but we needed them to help feed the residents. It was disgusting and dirty, eventually they hired an agency to clean the building. Floors were covered in spilled juice, body fluids. It was gross.”

The *Star* went on to add:

“Last March, Premier Doug Ford said that there would be an ‘iron ring of protection’ around Ontario’s seniors. Modelers predict the province will have more deaths in long-term care homes in the second wave than the first. Dr. David Fisman, a University of Toronto epidemiologist, says, ‘There never was an iron ring...just deprivation of contact with essential caregivers.’ Close to 40 per cent of the province’s 626 homes are now in active outbreak.”³⁰⁵

The promise of an “iron ring of protection” rings hollow. The reality is quite the opposite – the COVID-19 virus had ample opportunity to come into the deep-rooted cracks of nursing homes that had been allowed to develop over many years.

And once this lethal virus entered, nursing homes and government were caught flat-footed, failing to act with urgency, and unable to control the rampant spread of COVID-19.

In the face of government inaction, the apparent complacency of many long-term care facilities, and the too-frequent disregard for occupational health and safety, ONA was forced into action.

Taking Action During the First Wave

From the dawn of the pandemic, Ontario had fair warning about what needed to be done:

- On January 28, 2020, the ONA leadership of President Vicki McKenna and CEO Beverly Mathers, as well as Manager of Government Relations Lawrence Walter, met with Health Minister Christine Elliott and her Deputy Minister, Helen Angus, to discuss the readiness of the health care system for COVID-19. ONA raised the importance of the precautionary principle, the supply of personal protective equipment and pay for self-isolation (keeping workers’ pay whole when they are required to self-isolate due to an exposure). ONA also raised concerns about health care workers in long-term care who were working in more than one facility.
- On February 14, ONA wrote to the Ministers of Health and Long-Term Care about personal protective equipment and preparedness in all health care sectors.

- Five days later, on February 19, in a meeting with the Ministry of Long-Term Care, ONA raised concerns about the impact the number of part-time staff in long-term care could have on COVID-19 preparedness.
- On March 18, ONA raised concerns at the provincial COVID-19 labour advisory table about the personal protective equipment shortages in long-term care, workers working at more than one facility, and the lack of overall direction and guidance to the sector.
- In comments that were frequently echoed publicly, the government assured ONA it was prepared and had learned the lessons of SARS.

As the evidence in this report has demonstrated, nothing could have been further from the truth.

The government did too little too late, first only introducing discretionary guidance for nursing homes and no mandatory requirements until late March into April.

At the same time, the government relaxed minimum requirements for staffing:

Amending the exemptions to the 24/7 registered nurse (RN) requirement to provide staffing flexibility in cases where the pandemic prevents an RN from being present in the home.³⁰⁶

It also downgraded precautions for health care workers and abandoned the precautionary principle when it mattered the most, which prompted ONA into action.

On March 24, the Chief Medical Officer of Health issued Directive #3 applicable to long-term care homes. This initial version of Directive #3 was brief with a couple of guiding principles. It stated:

“...wherever possible, employers should work with employees to limit the number of work locations that employees are working at, to minimize risk to patients of exposure to COVID-19.”³⁰⁷

The wording “whenever possible” meant this guideline was easy to circumvent.



Nobody can say directions were clear and best. We found many gaps. Emergency order was selectively followed by our managers. –ONA member, survey response

It also recommended that residents should not leave the home for short-stay absences to visit family and friends and continued to permit visiting on the home's property with social distancing.

A revised version of Directive #3, issued on March 30, set out some basic infection control measures that should already have been in place, such as resident and staff cohorting to separate residents who had tested positive from the rest of the facility.

These early directives only required a lower level of droplet and contact precautions despite the old building design, poor ventilation, and congregate living centres of nursing homes.

ONA advocated that registered nurses on the frontline should determine the health and safety measures needed when delivering care. To that end, ONA negotiated a set of guiding principles to allow nurses to make these critical decisions. These principles were then relied upon by the Chief Medical Officer of Health to issue Directive #5 on March 31, 2020.³⁰⁸

At first, it was only applicable to hospitals. Directive #5 was later extended to long-term care homes on April 10.

Directive #5 granted registered nurses the right to decide, based on a risk assessment, what level of personal protective equipment they required when caring for a resident. The intent was to ensure that registered nurses – and not managers or government – would decide, based on their clinical judgment, what personal protective equipment was needed in each moment to keep residents and themselves safe.

This included the right to consider the evolving science and the precautionary principle in deciding whether to use an N95 respirator.

Nursing homes in Ontario also had the responsibility to not solely rely on government directives in order to take action. They also had a duty of care to act independently in accordance with the precautionary principle to protect residents and health care workers. This principle borne out of the SARS Commission was incorporated in many collective agreements between ONA and the nursing homes:

“When faced with occupational health and safety decisions, the Home will not await full scientific or absolute certainty before taking reasonable action(s) that reduces risk and protects employees.”³⁰⁹

Nursing homes were also bound by health and safety laws that required them to take every reasonable precaution in the circumstances of an unknown pathogen such as COVID-19.

The tragic reality is that nursing homes were unprepared and exposed to a dangerous new pathogen, often without basic pandemic plans and outbreak measures in place.

When the virus struck in late February to early March 2020, many nursing homes had not implemented basic infection control and health and safety measures such as designating an isolation room and processes to isolate infected residents. This was not limited to Anson Place or Madonna Care.

Further, many nursing homes did not honour the intent of Directive #5, trying to undercut the decision-making of registered nurses, or engage in public efforts in the workplace, often aided by infectious disease experts from local hospitals, to tell registered nurses they did not need an N95 respirator.

Worse, other nursing homes were more blatant in outright denying or ensuring personal protective equipment was not on the units and instead stored in locked rooms.

In the face of such inadequate workplace enforcement by the Ministry of Labour, ONA turned to the grievance arbitration process to keep its members, other health care workers and residents safe.

In the early days of the pandemic, ONA tried to schedule emergency hearings, but it initially proved too slow and bureaucratic, as employers refused to endorse measures that might have sped up the adjudication process.

ONA was left with no option but to go to Court.

It was only after ONA went to Court that employers became more responsive to scheduling expedited hearings.



I will tell you that the staff who were not good with N95s got infected – the staff that consistently wore N95s are still hanging in there. –ONA member, interview with ONA counsel

The Court Injunction

ONA started hearing troubling reports from registered nurses at three nursing homes owned by Rykka Care Centres (Anson Place, Hawthorne Place, and Eatonville Care Centre) and a fourth nursing home owned by Primacare Living Solutions (Henley Place).

Managers were placing N95 respirators under lock and key in their offices, discouraging, or denying nurses from wearing an N95 respirator when caring for COVID-19 positive residents. In some cases, registered nurses wearing a mask were told to take them off “for fear of frightening the patients.”³¹⁰

Management had taken over allocation of personal protective equipment and the decision-making as to when N95s and other personal protective equipment are used.³¹¹

This was contrary to Directive #5, which mandated that the registered nurse determine what personal protective equipment was needed in providing care for residents, including when to use an N95 respirator.

ONA also heard about improper infection control practices in nursing homes where positive and negative residents were sharing four-bed ward rooms in close quarters, separated by a mere curtain. Both negative and positive residents were treated by the same staff. Residents were intermingling freely in common spaces such as the lobby.

This was contrary to Directive #3, which mandated that both residents and staff must be cohorted into contagious and non-contagious groupings.³¹²

Faced with this dire situation, ONA desperately knocked on many doors, seeking provincial enforcement of these directives, the precautionary principle, and health and safety laws.

As described in the last chapter, ONA alerted the Ministry of Labour, public health units, and the local medical officer of health of its grave concerns that “residents and staff are not being cohorted as required by the applicable Directive #3”³¹³ and that N95 respirators were being denied to health care workers.

The Ministry of Labour did not issue orders. The local medical officer of health did not address serious safety breaches that put residents at risk.

This despite the fact that there were public health directives that were mandatory but they were not being enforced.

Faced with inaction by the local public health system authorities, ONA filed grievances at 200 nursing homes, who were covered under a central collective agreement and are known as the “participating nursing homes.” The grievance claimed that these nursing homes had not taken every reasonable precaution to protect registered nursing staff and residents.

ONA had evidence that the issues at the four nursing homes were also occurring at other long-term care facilities across the province, signaling a broader systemic problem across the province.

Therefore, on April 9, ONA proposed a central expedited arbitration process for the 200 participating nursing homes to schedule a fast-tracked hearing on April 15 for a labour arbitrator to answer the following question:

“Have the participating nursing homes taken the required health and safety measures to ensure the safety of registered nurses and health care professionals in accordance with the collective agreement, including the precautionary principle, the *Charter of Rights and Freedoms*, the *Occupational Health and Safety Act*, and any other relevant legislation?”

The representative for the participating nursing homes turned this proposal down on April 11, underscoring growing evidence that the labour arbitration system in Ontario, unfortunately, was ill-equipped to deal with a public health emergency.

Absent effective enforcement by the Ministry of Labour and public health, ONA and its members – and the long-term care residents and health care workers they were trying to protect – were left to the whim of the employer consenting to an expedited process on urgent matters of life and death.

Without such consent, the only option remaining was for ONA to seek “expedited arbitration” under the *Labour Relations Act*. This permits a trade union to request the Ministry of Labour to appoint an arbitrator and to have a hearing scheduled between a 30-to-51-day window from the time a grievance is filed.

An expedited action in labour relations is a far cry from the need for urgent action during a public health emergency.

In Ontario, arbitrators also have no power to issue interim or temporary relief like the Courts, pending the grievance working its way through a hearing process.

ONA rejected using the option of a Ministry-appointed arbitrator, as its members and residents needed protections in place immediately with COVID-19 spreading quickly every day.

ONA pivoted and prioritized the grievances at the three Rykka homes and Henley Place. On April 14, 2020, ONA wrote to each of these nursing homes, proposing immediate arbitration hearings due to the dire situation at hand and the urgency needed to avoid further harm:

“As you are aware, the above noted grievance raises urgent issues regarding the health and safety of ONA members during the unprecedented COVID-19 pandemic.

In order to avoid irreparable harm to our members, we are seeking the Employer’s agreement to have the grievance heard by an arbitrator mutually appointed by the parties on an expedited basis, with agreement to a video conference hearing date scheduled by no later than April 17, 2020.”

The nursing homes’ representative denied the request in a brief response that offered little explanation. The representative asserted there was no breach of the collective agreement and public health directives issued by the Chief Medical Officer of Health.

ONA knew this was not the case based on direct evidence from registered nurses.

With every door shut, ONA took the extraordinary step of seeking an interlocutory injunction from the Superior Court of Justice. ONA asked that the Court order the nursing homes to provide nurses with immediate access to N95 respirators and other personal protective equipment, and to cohort and isolate residents.

ONA filed its Court papers on April 16 and the Court granted a hearing date six days later on April 22. As each day passed, the rate of infection was growing at alarming rates at these four nursing homes. By the time ONA appeared in Court, the numbers were grim. Some 110 residents had contracted COVID-19. There were 54 resident deaths. Seven nurses had contracted COVID-19 with at least one member hospitalized.

The Court agreed that it offered the last option for relief to ONA and its members, and that ONA had nowhere else to turn:

“The real problem raised by this labour dispute is that the arbitral process is a slow and protracted one. In effect, this leaves this court’s inherent jurisdiction as the only legal mechanism to realistically fill this void.”³¹⁴

Justice Morgan issued his landmark decision on April 22. He concluded that Directive #5 required the four nursing homes to listen to the clinical experience of nurses by,

“...giving the final word on whether the delivery of care to a resident of a LTC facility requires specific health and safety measures or PPE including N95 to the nurse at point of care...the nurse is not directed to call management personnel to weigh in on the issue at point of care.”³¹⁵

What began as a labour dispute landed in the Courts as an effort to seek emergency relief not only for registered nurses but also for residents. Typically, labour arbitration focuses on employees, but ONA and its registered nurses knew that it was essential to be the voice for residents who had no voice.

Registered nurses therefore took their advocacy for residents from the bedside to the Courts.

Following this victory, the participating nursing homes, approached ONA to finally agree to an expedited arbitration process that had been proposed weeks earlier. On May 2, the parties agreed to John Stout as the sole arbitrator.

As ONA’s legal team gathered evidence, they learned that, despite Justice Morgan’s decision, nursing homes were still breaching safety measures and the right of nurses to decide what protections they needed.

This challenge was not limited to a few nursing homes but was widespread and part of a broader systemic problem with common themes: failure to isolate and cohort; ongoing denials and locking up of N95 respirators and other personal protective equipment; failure to follow infection control and safety measures; resident surveillance; lack of timely employer communication; and inadequate training.

This continued despite Justice Morgan's decision.

Some of the evidence of the registered nurses is set out below:

"The Home has not been transparent with its employees regarding which residents and staff have tested positive or are otherwise symptomatic with COVID-19. I was advised during our daily morning meeting that a resident on my floor, K, began developing symptoms of COVID-19. At a later time, a colleague informed me that K tested positive for COVID-19. I was disappointed that I found out this information from a co-worker but not from management."

"The procedures in place at the home are not sufficient in protecting the staff from getting sick when caring for COVID-19 suspected or confirmed patients. In my professional judgement, the infection control practices in the home are sorely lacking and are leading to the spread of COVID-19 among the residents. [RN] had concerns because this resident had been tested for COVID-19 days before and the results had not been received due to common symptoms of COVID-19, including frequent coughing and sneezing. [RN] was providing general care to the resident and conducted a PCRA. She determined that because the resident was exhibiting common symptoms of COVID-19 she felt she may be at risk. As a result, she requested an N95 mask from the Assistant Director of Care but was denied access to the facility's supply of masks. She then requested an N95 mask from another ADOC and was similarly denied despite reporting the resident symptoms and lack of personal infection control measures such as covering up when sneezing or coughing. She was advised that a surgical mask would be sufficient PPE for her provision of care in the circumstances."

"...the facility has not taken sufficient and precautionary measures to separate residents that are suspected and exhibiting symptoms of COVID-19

and those that are not. Residents are permitted to wander around their respective units. This also includes residents that suffer from dementia. There has been no concerted effort or direction to ensure residents exhibiting symptoms stay in their room, and/or do not interact with other residents and common areas."

"The nursing staff do not have access to the facility's PPE as it is stored and locked away in the Infection Control Manager's office."

"An RN was asked to conduct swabs of residents that exhibited symptoms of COVID-19. The RN requested an N95 mask after having made a point of care risk assessment based upon her professional and clinical judgment. She was testing residents suspected of having COVID-19 because they were exhibiting the common symptoms. Despite meeting the criteria under Directive #5, the request for appropriate PPE was denied by the facility."

"There have been no meetings of the JHSC or IPAC Committees for the past several months. Indeed, where such meetings have been scheduled to occur, they have been cancelled by the employer."

"...ONA members raised concerns with the employer regarding its stock and supply of PPE, and were told by the home's Director of Nursing that the supply had been 'dealt with' and that it was currently being 'locked' in an 'undisclosed location.' I understand the Director further advised staff that the facility was 'saving' this PPE for when it was 'absolutely needed.'"

"...ONA members raised concerns about the use of agency staff in the facility during the same huddle, noting that they could have been exposed to COVID-19 at some of the other facilities they worked at, and could potentially expose staff and residents to the disease. The Director of Nursing advised staff at this time that the facility was short-staffed and that agency workers would continue to work at the facility without any restrictions or limitations until further notice."

"...at a 'huddle' that took place in or around mid-March 2020 ONA members raised concerns that social distancing protocols were not in place at the facility, and that this could have a detrimental impact on the health and safety of residents and staff. I understand that staff were simply told in response that the nursing home was following the direction of Ontario Public Health."

“...starting in or around early April ONA members were given a single surgical mask when they attend in the mornings. The surgical masks are given plastic Ziploc bags to place the mask in when this mask is not in use. If the mask becomes soiled or wet, staff are required to justify to management why another mask is required.”

“I asked the Director about the N95s and she aggressively affirmed that N95s were not necessary in a long-term care setting. She confirmed the direction that all staff were being given at the time, which was to use surgical masks (the two that people were given per shift) unless going into a room with a suspected/confirmed COVID-19 resident, in which case you would remove your surgical mask and put on a mask with a visor.”

“When I arrived for my shift, I was distressed to see how little cohorting and isolation had been implemented. The COVID-19 positive residents all had other residents in their rooms. There was no extra cleaning in their rooms, particularly of shared bathrooms, as there was a staffing shortage... asymptomatic patients from both wings were also still being allowed to move around the home freely, eat in the communal dining room and congregate in common areas.”

“Since the COVID-19 pandemic, the [nursing home] has seen an increase in staffing issues and base staffing levels have seldom been met. This staffing crisis has occurred for many reasons, which I believe include:

- The fact that the majority of the registered staff, such as registered nurses, are part-time or casual rather than full-time, which resulted in the home losing a large number of RNs as well as RPNs when staff members were required to choose only one employer;
- The decision to move the PSWs to 12-hour shifts rather than 8-hour shifts;
- The fact that some staff elected not to come to work after the first COVID-19 positive case was announced; and
- The fact that many staff have now tested positive for COVID-19.”

“Among my other concerns, the home has undertaken no resident or staff cohorting. I even received a call from an angry family member who stated the home

is irresponsible for leaving a non-COVID-19 resident in the same semi-private room as a COVID-19 positive resident. At the time of my last shift of work, I was aware of at least three circumstances, included the one noted above, where one resident in a semi-private room was diagnosed with COVID-19 and the other was not. No efforts have been made to separate these residents.”

“We had N95 masks for that entire weekend. On Monday...however, management removed all N95 masks from the affected unit and the pandemic supply room, as well as the fit-testing book. I am not aware of where these were moved. Staff were informed that N95 masks were not required for care.”

“On or about mid-April, 2020 I came in for my shift and a resident had just died a couple of hours before I started. There was a sheet on the nursing desk outlining that there were new procedures surrounding how we were to manage the resident’s death. The new procedure included that the funeral home staff would no longer come into the home to retrieve the body. Instead, staff are provided with a stretcher and a body bag outside, and then told to transfer the dead body into that bag and onto that stretcher. We are then expected to sanitize the bag and roll the stretcher back outside to the waiting funeral home staff. Prior, the funeral home staff, who were usually dressed in full one-piece personal protective white suits with full face coverings, would come into the home to transfer the body.”

“I was not provided any information or training from management about this new process, including, importantly, infection control procedures. I had several concerns with this practice, which has continued to date. Most concerning to me is that our staff are not provided with appropriate PPE to complete this newly assigned task. We are expected to bag the body using our assigned gowns, gloves, and surgical masks. This is regardless of whether the resident was COVID-19 positive.”

“Based on my efforts, we were able to have this resident moved to the private room by Saturday afternoon. This delayed process resulted in at least 18 hours where the COVID-19 positive resident was left in the basic room, which placed the other three residents in danger of contracting the virus. There is no proactive approach by the home to separate positive and negative residents in a timely manner.”

“In late March 2020 we received a new admission from a [hospital]. She was admitted to a ward room. I was aware that the hospital had COVID-19 cases at the time, and so asked the Administrator that this resident be moved to a private room and isolated, as one was available that day. The Administrator told me it wasn’t necessary, but that she would take my request to Head Office. I never heard back. Last week, this resident tested positive for COVID-19 and was moved from that ward room to a private room after her positive test result.”

“Since the outbreak, we have been told that if we need to use an N95 respirator, it must be requested from the home’s Administrator who has them locked up in her office. I believe that only the Administrator and the reception desk have keys to her office.

“I personally voiced my concern about the lack of accessible PPE, including N95 masks, in accordance with Directives #3 and #5 at a staff meeting on April 22, 2020. When I asked why we are limited to two masks, the DOC responded that the home is in a ‘unique position’ because we are not in outbreak. I observe that the practice of reuse and extended use is contrary to all recommended infection control practices with which I am familiar by virtue of my education, training, and experience.”

Reflecting the breadth and weight of the registered nurses’ evidence, this led to a landmark arbitration decision on May 4, 2020 by Arbitrator Stout, ordering nursing homes to implement a wide range of infection control and health and safety measures to respond to COVID-19, including engineering, administrative and personal protective equipment controls.

Arbitrator Stout stated once again that the purpose of the award was to protect both health care workers and residents:

“Instead, an immediate full and final binding decision is required to provide the parties with guidance to move forward, working together to care for our most vulnerable elderly citizens.

After spending a number of days with these parties and reviewing all the evidence they provided to me, I am of the view that this Award must provide a path forward in a more positive way so that the parties can work jointly in their struggle to combat this terrible disease and protect our valuable healthcare workers and the Homes’ vulnerable residents. As indicated earlier, the parties share mutual goals.”

The award ordered the following measures:

- **Administrative Controls:** Nursing homes were required to implement physical distancing measures, training on infection control and proper use of personal protective equipment, and vigilant resident and staff screening for COVID-19.

They had to notify staff immediately of positive residents so safety precautions could be put in place.

Staff who were infected with COVID-19 were not permitted to return to work until they were cleared of the infection by testing or a 14-day isolation period.

The nursing homes had to make available to the joint health and safety committee outbreak and pandemic policies.

The award also called for enhanced and in-depth cleaning.

- **Joint Health and Safety Committee:** The nursing homes had to ensure a functioning joint health and safety committee was in place and meeting regularly.
- **Supply of Personal Protective Equipment:** Employers agreed to make best efforts to acquire personal protective equipment, to share their available supply records with the joint health and safety committee, and to ensure everyone was fit-tested for N95s.

Arbitrator Stout also ordered that nursing homes were required to provide registered nurses access to fit-tested N95 respirators and other personal protective equipment when determined by the nurse to be appropriate and required following their risk assessment.

The Arbitrator granted registered nurses the power to consider the current science and evidence respecting COVID-19 transmission and the circumstances in the home when making this decision.

Registered nurses were also entitled to consider a broad range of neuro-psychiatric behaviours, symptoms or other conditions of residents that resulted in the expression of aerosols during routine care.

Nursing homes also had to ensure that registered nurses had ready access to all sizes, and personal protective equipment, such as N95 respirators, was not locked up.

Arbitrator Stout also ordered the homes to implement administrative controls such as isolating and cohorting of residents and staff during the COVID-19 crisis and any subsequent waves, as set out in directives issued by the Chief Medical Officer of Health.

“A constant battle” – The Experience of a Registered Nurse in Long-Term Care

“I was retired and came back to this facility because they had a COVID-19 outbreak.

To see the staffing the way it is...pathetic on a good day. There is often one RN in the building. She is on a med cart passing medications on a hallway, which could be upwards of 30 to 35 residents. She is also responsible for the whole building, which has around 120 residents in the building.

Infection control was a constant battle. I told them you cannot have proper infection control with four residents in a room. There is no such thing as magic curtains! I had to take people out of a four-bed ward and put them in a TV room because there is nowhere to put them. I fought that we needed at least one room for isolation in case we needed it.

We should not have to wait for a pandemic to do proper infection control. Everything you learn about IPAC is no four-bed ward rooms, period. End of story.

One patient had to be moved out urgently. He had a temperature in the afternoon and was in a four-bed ward room. I told the manager we need to get him out. He is coughing. I told her that I needed a private room. Where do I put him? Her reply was: ‘I don’t know.’ I said are you serious, no plan for an outbreak? They had from March to November, they are still admitting patients into semi-private rooms that I could have used as isolation rooms.

I was so angry. I went to the leadership in the home and said I should never have to go through that again and we need to have a written plan in place as to what we are going to do when it happens again.

They had a meeting, which I attended. They developed a written plan and now they have semi-private rooms that I can use, which we use all the time, including for patients that come back from hospitals.”

Second Wave

Over the summer months, ONA became increasingly concerned that, despite the rulings of Justice Morgan and Arbitrator Stout, nursing homes were not preparing for the second wave.

ONA wrote a letter in late October to nursing homes across the province advising them of the need to take proactive steps to be ready for the much anticipated second wave:

“It is imperative that the long-term care sector is prepared, particularly because the influenza season is also approaching. The levels of resident and staff infection, and sadly, death, which we experienced this spring can and must be avoided. Sufficient measures need to be in place now to ensure that residents and staff are protected.

ONA is writing to put you on notice that we expect the home to take all reasonable and necessary steps and precautions to ensure that the home is prepared to face the second wave of COVID-19. At a minimum, the home should already be in compliance with the collective agreement, the *Occupational Health and Safety Act*, the John Stout award dated May 4, 2020 and all guidance and direction from public health, the Chief Medical Officer of Health, and the Ministry of Long-Term Care.”

The ONA letter detailed all the measures ranging from infection control, adequate stocks of personal protective equipment, and staffing that ought to be in place sooner than later.

It quickly became clear that this warning and advice was being disregarded, despite repeated assurances that safety precautions were in place, including the measures set out in the Stout Award.

Registered nurses, however, faced ongoing struggles with nursing homes that still did not comply with public health directives, health and safety measures, and other measures ordered by Justice Morgan and Arbitrator Stout.

With the coming of the second wave of COVID-19, further cracks in the pandemic response in long-term care were revealed. This put ONA in the predicament of again being forced to take on the government’s (largely vacant) enforcement role.

The next section sets out how once again ONA met this challenge in a labour arbitration system and fought to protect all health care workers and residents.

Failure to Keep Up with Science of Airborne Transmission

As the second wave was beginning in late summer 2020, the world was seeing a growing acknowledgment that COVID-19 could spread through the air, adding to the weight of the already significant evidence that contact and droplet precautions were inadequate.

Some long-term care facilities, however, were doubling down on efforts to convince registered nurses that this was not the case, and that N95 respirators were only needed for aerosol generating procedures.

Employers – sometimes with the support of infection control staff seconded from hospitals – were making statements on airborne transmission that were at variance with both evolving scientific evidence, and the advice of unions and occupational health and safety experts.

The current consensus on airborne transmission demonstrates how right registered nurses were in their clinical judgment, and how wrong public health and infectious disease experts were.

Despite the orders of Justice Morgan and Arbitrator Stout, employers continued during the second wave to lock up N95 respirators, not fit-test health care workers, and not replenish personal protective equipment supplies.

In the middle of September, as an example, management at one facility hosted a conference call involving an infectious disease specialist from a local hospital to reinforce a message that was contrary both to the science and to the Morgan and Stout decisions.

As an ONA Labour Relations Officer noted afterwards:

“Once again [it is] hard to tell our members that if you are on this COVID-19 outbreak unit to protect yourself by wearing an N95 when the Infectious Disease physician, public health and the employer are all saying you don’t need them.”

This incident was not an isolated one.

In late October, the manager at another nursing home, sent an email to staff with a similar message:

“Today’s big focus ****PPE****

COVID-19 virus is spread via the mouth, nose, and eyes**

Protect your mouth and nose with your mask

Protect your eyes with your visor & Hand Hygiene

Droplets & Contact **

Staff Cases= 11

Resident Cases = 22

Resident Death= 1

[Name omitted], IPAC [Hospital name omitted] who has been in MANY outbreak homes, [Name Omitted] NP who has been in MANY outbreak homes (35+ outbreak homes) – have both never worn an n95 mask and they have not contracted COVID. COVID is contracted if there is a breach in PPE- you put it on and wear it properly, you take it off properly. We ask you to please listen to what is being educated and enforced.

We thank all of you that have continued to show up for each other and the residents.

Eat, Sleep, Hydrate, Breathe, Repeat... Big breath in, big breath out.”

What is striking about the email is that they seem to have happened in a time warp – detached from the actual state of the science on COVID-19 airborne transmission.

Let’s explore this further.

Months earlier, on June 1, 2020, an analysis of 172 studies, funded by the World Health Organization (WHO) and published in *The Lancet*, confirmed what unions, scientists and occupational health and safety experts had been saying for months: Surgical masks are inadequate protection against COVID-19 and medical workers should, instead, be wearing N95s respirators.³¹⁶



Now it is coming to light that it is airborne. I said this from the beginning. I asked all day, everyday, please provide N95s. –ONA member, interview with ONA counsel

“A fire I could not control” – The Experience of a Registered Nurse in Long-Term Care

“I am on stress leave. The big thing is that I never knew from one minute to the next who will be there for staff. Since the outbreak, people started to get panicky and fearful. As residents became sicker, we had to do more assessments, and more people were calling in sick with symptoms.

I approached management at the time and said I cannot juggle all the balls. It was simply not possible. They said you can reach out to us, but trying to get a hold of everyone [was impossible].

Visualize this. Just pretend you are a fireman and you only have two people – trying to control a fire with only two other people. I do want to help. I became a nurse to help people but I feel very unsafe for everyone involved. This is why I backed away from the fire. I was not getting the support. We were told we were getting agency but then they didn't show up. It was like buckets with no water in them.

We were short-staffed one night, two nurses called in sick that night. So we only had one RPN and one RN for the whole building. That is when it became my personal vision of a fire that I could not control. It was so unsafe.

This was preventable. There was no plan for the outbreak. Everything kind of came together at the time of the fire – the home started to get organized then.

They did not move residents out of semi-rooms where there was a positive resident in a home and we didn't know the status of the other resident. They could have easily used certain areas for putting the ones that were in the rooms and separated them and we have done that before for other types of outbreaks.

I recommend communicate, communicate, communicate. Things have to be communicated. We need leadership. Preparedness – it is essential to be more prepared.”

Then, one month later, in July 2020, 239 experts from 32 countries, including Canada, wrote a letter to the WHO, calling on it to revisit its resistance to growing evidence of airborne transmission.

Suggesting that it is precisely during a time of scientific uncertainty that the precautionary principle should be invoked, the authors noted:

“It is understood that there is not as yet universal acceptance of airborne transmission of SARS-CoV-2; but in our collective assessment there is more than enough supporting evidence so that the precautionary principle should apply. In order to control the pandemic, pending the availability of a vaccine, all routes of transmission must be interrupted.”³¹⁷

Later in July 2020, in an apparent response to this letter, the WHO changed its tack, acknowledging for the first time “evidence emerging” of the airborne spread of the novel coronavirus.³¹⁸

In September 2020, Dr. Anthony Fauci, one of the world's leading experts on COVID-19, said in a lecture at Harvard Medical School that with regards to airborne transmission:

“We've really gotten it wrong over many years...the bottom line is there is much more aerosols than we thought... Because, if you look at what we knew in February compared to what we know now, there really is a lot of differences that are there right now – the role of masks, the role of aerosol, the role of indoor vs outdoor, you know, closed spaces.”³¹⁹

In early October 2020, the U.S. Centers for Disease Control and Prevention acknowledged airborne transmission.³²⁰

By mid-October, even Canada's top public health official, Dr. Teresa Tam, signaled it could be time to revise federal guidance to provinces on how to prevent airborne COVID-19 infections.³²¹ Tam's Public Health Agency of Canada would itself acknowledge aerosol transmission in early November.

While this scientific debate was being resolved, publicly and in real time, in favour of airborne transmission, the above-noted email highlights how many long-term care facilities – supported by public health and infectious disease specialists – were stubbornly clinging to the increasingly outdated science that COVID-19 did not spread through the air.



They were giving us one surgical mask for four days at the beginning and insisted we would not need N95 masks. –ONA member, survey response

ONA kept receiving member complaints that Directive #5, the decisions of Justice Morgan and Arbitrator Stout, and the emerging science were being frequently disregarded.

In each case, in the absence of government enforcement, ONA was forced to send letters demanding that registered nurses immediately be able to access N95s and for the campaign to discourage the wearing of N95s to stop.

The following is an example from one such letter:

“We are advised by one of the RNs that staff are being actively discouraged from requesting N95s. They are advising staff that N95s are only to be used for AGMPs and are not to be used in any other circumstances. They are only allowing staff to wear N95s if they are working with patients on CPAP. They have even gone so far as to say to staff that they should not wear N95s because they might leave marks on their faces. This is entirely unacceptable, and clearly contrary to the legal obligations of the nursing home.”

Obstinacy in Personal Protective Equipment Refusals

The frequency with which some nursing homes continued to refuse N95s to registered nurses was both surprising and acutely alarming.

A case in point is set out in the following chronology involving the ping pong-like, back-and-forth between ONA and its members, and one home:

October 17, 2020: A registered nurse at the home told ONA: “Management still refused to supply us with N95 mask. We have the supplies, but they are not giving it to the nurses.”

October 20, 2020: The home went into outbreak.

October 20, 2020: ONA Labour Relations Officer inquired about how many residents and staff had been infected, whether residents were being isolated and cohorted, and whether staff had access to personal protective equipment.

October 20-21, 2020: Employer provides staff with one N95 per shift. Other supplies were locked up, and only available from managers. Managers continued to downplay the need for N95s.

October 22, 2020: Employer told ONA that 14 residents and 10 staff tested positive, and that contrary to claims of rationing, staff had full access to personal protective equipment, including N95s. In fact, ONA heard from registered nurses that:

“The staff only have free access to gowns and gloves. Staff have to approach management for access to shields, goggles, and N95s (under lock and key). And only staff working on the COVID-19 floors can ask for the personal protective equipment that is under lock and key.”

October 23, 2020: Since the home was disregarding Directive #5 and the binding legal order of Arbitrator Stout, ONA sent a demand letter stating:

“We are advised that there are significant restrictions on access to PPE. Staff only have unfettered access to gloves and gowns. Staff working on the floors with residents who have COVID-19 are still required to request face-shields or goggles, as well as N95s from management. All of this PPE is locked up. Staff on other floors only have access to gloves, gowns, and surgical/procedural masks. This is clearly contrary to Directive #5, the *Occupational Health and Safety Act*, Mr. Stout’s award, which binds this home, and the collective agreement. The home must immediately cease and desist, and provide staff with unfettered access to the PPE, which they determine is required based on their point of care risk assessment.”

ONA also demanded immediate cohorting and separation of infected residents from healthy residents on separate units or areas.

October 26, 2020: Nursing home begins providing different types of N95s on units affected by COVID-19. ONA asked for details on N95 supplies and whether the sizes on the units matched the needs of fit-tested staff.

October 27, 2020: ONA repeated its request for this information, and also asked that the home confirm that nurses had the right to decide when they needed an N95. Because the nursing home was not forthcoming, ONA decided to go back to Arbitrator Stout for information about the N95 stockpile, fit-testing, and access.

October 29, 2020: Registered nurses were again saying that they had to get approval from their manager to get N95 respirators if they could not access one on the unit. To make matters worse, infectious disease practitioners from the local hospital were telling nurses that they did not require N95 masks when providing care to suspected or confirmed COVID-19 residents.

October 30, 2020: Registered nurses were told they were supposed to use one N95 respirator for the entire shift even though about 90 per cent of residents were coughing and had other respiratory symptoms. Positive and negative residents were being housed in one unit.

November 4, 2020: Issues were resolved after discussions between lawyers for ONA and the employer.

It is stunning that after the Morgan and Stout decisions, after Directive #5, and after the growing consensus involving airborne transmission, that some homes are still putting up such a strong fight against not only doing what they are legally required to do, but also what is in the best interests of their residents and of their employees.

Conclusion

During the first and second wave of COVID-19, registered nurses were not only caring for their residents but fighting for the protections they and their residents needed.

Unfortunately, nursing homes are still failing to provide registered nurses with the tools they need to keep everyone safe.

ONA has continued to fight to get registered nurses what they needed at their fingertips, whether training, communication, personal protective equipment, cohorting of residents, or other measures – and to ensure nursing homes are acting to protect their residents before and during treacherous outbreaks.

Despite being subject to directives and legal orders, ONA often had to monitor the homes and ensure compliance, trying to fill a significant gap in inspections and enforcement for nursing homes by Ministry of Labour inspectors and public health authorities.

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Chapter 9

Recommendations from the Front Lines

9

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Introduction:

COVID-19 revealed a chasm between the glossy promises of nursing home brochures and television ads and the grim reality of a long-term care system that had stubbornly defied meaningful reform, despite scores of recommendation-rich inquiries – and a myriad of (unfulfilled) promises by generations of politicians.

Nursing homes with decades of experience containing yearly outbreaks of the influenza, rhinovirus, and gastrointestinal viruses could not stop the spread of COVID-19. Precautions and resources that should have been in place to protect health care workers and residents were not. An unbearable toll of death and disease ensued.

As of January 23, 2021:

- Second-wave cases of COVID-19 among long-term care residents is 7,918 and for staff is 2,918, exceeding the first wave totals when 5,936 residents and 2,638 staff were infected. The second wave is not yet over, and the case count grows every day.
- The death rate of long-term care residents due to COVID-19 during the first wave alone is 1,823. To date, the death rate of residents during the second wave has reached 1,560 and continues to climb.

As of July 3, 2020, health care workers comprised roughly 73 per cent of Workplace Safety and Insurance Board accepted and pending cases related to COVID-19 claims.³²² Of those claims, 85 per cent were made by women.³²³

COVID-19 revealed that health care worker safety and resident safety are two sides of the same coin. Protect workers and you protect residents.

As the Director General of the World Health Organization (WHO), Dr. Tedros Adhanom Ghebreyesus, has stated:

“The COVID-19 pandemic has reminded all of us of the vital role health workers play to relieve suffering and save lives... No country, hospital or clinic can keep its patients safe unless it keeps its health workers safe.”³²⁴

Prominent researchers on long-term care, Pat Armstrong and Marcy Cohen, put it this way: “The conditions of work are the conditions of care.”³²⁵

Addressing the quality of care requires addressing the quality of the conditions under which care is provided. If the work environment is unsafe, it is also unsafe for residents.

This chapter will give a voice to registered nurses with direct clinical experience working with COVID-19 residents and present their perspectives on the solutions needed to control the spread of COVID-19, and safeguard against future public health emergencies.

A Failure to Listen

From the outset of the pandemic, registered nurses were fighting two battles: one against an invisible virus; and the other against nursing homes that were failing to protect their residents and health care workers.

The tragedy is that registered nurses knew what needed to be done. Over and over, they and their union advised employers on everything from cohorting to infection control, but no one listened even though registered nurses likely have had more clinical experience with COVID-19 than any other health care professional.

One registered nurse explained:

“I was constantly telling them to shut down the elevators and bring residents in from smoking out front. They didn’t pay attention. We were telling them this for two weeks, but they didn’t listen. After a staff member became positive, they said the residents have to stay in the rooms because the residents were still coming out for a smoke.”

A registered nurse at another home, responsible for scheduling, reported:

“A profession that is not respected! We have been complaining about staffing shortages for many years, but no one listened or took us seriously until the military went into homes and saw how dire the situations are!! LTC staff and residents are overlooked and not respected the way other health care staff and patients are in hospitals!!!”

A registered nurse at a different home stated:

“Management needs to listen to us. One thing that I found is management is making decisions and not consulting with registered staff. They are acting out of ignorance because they don’t know the residents and they don’t know their needs. One of the managers made a med error in the early days of COVID-19 because they gave out the medication wrong to residents.”

A third registered nurse explained:

“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 told us to take the highest level of protection until evidence shows that it is not needed. LTC was not provided with the basics and even today, N95s are in limited supply. Government is making decisions without front-line workers at the table. The second wave is coming and they are still not prepared.”

When registered nurses were forced by employer and government inaction to go to Court to protect residents and all health care workers, some long-term care homes suggested registered nurses were simply acting in self-interest.

According to Justice Edward Morgan, this claim was without foundation:

“...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 [registered nurses’] 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.”³²⁶

COVID-19 brought to the forefront the breadth and persistence of disquieting gender and racial inequities in long-term care.

These gender and racial inequities inform our understanding of the systemic reasons why the clinical judgment of registered nurses was disregarded and marginalized throughout COVID-19.

Registered nurses in long-term care are in a profession that is 90 per cent female in an industry where Boards of Directors of the largest players remain male dominated:

- The Board of Directors of Sienna Senior Living – among the largest long-term care providers in Canada and the owner of Altamont Care Community in Scarborough where 52 people have died of COVID-19³²⁷ – is comprised of five men and two women.
- The Board of Directors of Revera – one of Canada’s largest long-term care providers and the operator of the Westside nursing home in Etobicoke where 100 residents and 50 staff tested positive and 12 residents died³²⁸ – consists of seven men and three women.
- The Board of Directors of Extendicare – which owns more than 100 long-term care facilities across Canada and managed Orchard Villa, a facility with 77 deaths, 96 staff and 225 residents testing positive for COVID-19³²⁹ – is comprised of six men and three women.

The inequities revealed by COVID-19 also help contextualize the heavy toll the pandemic has taken on racialized health care workers.

An Ontario Nurses’ Association (ONA) survey of its members in long-term care found that:

- A higher percentage of respondents who identified as being racialized indicated they tested positive (six per cent) than those who identified as non-racialized (three per cent);
- 63 per cent of racialized respondents said their home had an outbreak compared to only 40 per cent of non-racialized; and
- Outbreaks experienced by racialized respondents were more likely to have greater than five resident infections (60 per cent), whereas non-racialized respondents were more likely to experience outbreaks involving five or fewer residents (70 per cent).

The failures and inactions of long-term care homes and government point to more profound and deep-seated systemic problems.

The academic literature has consistently found that

“Care work is socially regarded as work to which women are naturally predisposed; it is thus essentialized as feminine labour and considered unskilled, which facilitates devaluation.”³³⁰

It is hard not to link the disregard of registered nurses’ clinical judgment during COVID-19 – and by extension their training and expertise – to the broad devaluation of professions that are predominantly female.

Too often, registered nurses are not seen as professionals who receive rigorous education and have valuable clinical experience. It is troubling that, too often, they are not regarded as clinicians with insights on par with those of physicians and other members of the health care team.

As one nurse states, *“LTC has been put aside by greedy politicians for years. No one cares about LTC and it shows. Female-dominated professions are being neglected.”*

If long-term care is to be reformed, if we are to give our seniors the safe environments that they have a right to enjoy, then these gender and racial inequities must be addressed to ensure equality for the women who provide health care.

Part 1 – Perspectives on Transforming Long-Term Care: The Role of Employers

A Culture of Safety

SARS demonstrated the importance of a strong safety culture. Its key elements include: close co-operation between infection control and worker safety experts, including occupational hygienists, engineers trained and specializing in workplace safety; listening to workers’ concerns; and ensuring workers have a dynamic role to play in their workplaces through effective internal responsibility systems.

A leading health and safety study that was completed following SARS concluded:

“Workplace attitudes towards safety were also seen as important [among health care workers]. Paramount to this were the attitudes and actions of management and the perceived importance of occupational health and safety, both of which were important determinants of the safety climate within hospitals.”³³¹

COVID-19 has reaffirmed an important lesson from SARS: health care worker safety and outbreak containment go hand in hand.

Protecting health care workers breaks the chain of transmission. If health care workers are protected, they cannot be infected by patients, residents or their colleagues. Conversely, if they are protected, they cannot infect their patients, their residents, their colleagues and their families.

As Justice Campbell noted, protecting health care workers during a pandemic has a positive knock-on effect by helping to mitigate a pandemic’s human, societal and economic negative consequences:

“One of the strongest lessons from SARS is that the health and safety of health care workers and other first responders is vital in a public health emergency. SARS demonstrated that an emergency response can be seriously hampered by high levels of illness or quarantine among health care workers.”³³²

The high rates of infection among health care workers in long-term care is evidence of both poor workplace conditions, and that the lessons of SARS on protecting health care workers went unheeded.³³³

Research that specifically investigated the link of infectious disease exposure and workers’ health and safety has found that the safety climate of a workplace correlates to better compliance with precautions against blood-borne pathogens.³³⁴

Some may suggest that the workplace risks of disease exposure are just part and parcel of working in a health care setting. In fact, these risks can be eliminated and reduced. Registered nurses became nurses to care for people, not to put themselves and their families at unnecessary risk when the means of protecting them are widely known but largely disregarded.

As one registered nurse said: *“I didn’t sign up to die on my job.”*³³⁵

Staffing and Clinical Outcomes

Pre-COVID-19 research demonstrated a link between the level of nursing clinical care and expertise and patient mortality outcomes:

“...leading studies of hospital inpatient mortality rates have found that the number of nurses present for care is the single most important factor affecting

mortality rate after controlling for all other hospital structural and financial factors with use of risk-adjusted measures. Indeed, a higher ratio of RNs to patients or RNs as a percentage of total nursing personnel has been associated with lower hospital mortality rates in several studies.”³³⁶

Nevertheless, the proportion of registered nurses in the long-term care sector has decreased since 2013, according to a government-commissioned Ontario staffing study. This, despite the overall increases to resident acuity.³³⁷

Respondents to ONA’s Long-Term Care Survey said that long-term care homes were often short of registered nurses. More than half of respondents (51.7 per cent) said their home was short of registered nurses either frequently (once a week) or often (several times a week). Adding to the workload of registered nurses, was that these homes were also short of personal support workers (PSWs). More than 80 per cent of respondents said their home was short of PSWs either frequently (once a week) or often (several times a week).

Pat Armstrong, the preeminent authority on the quality of care in long-term homes in Canada, believes that staffing is the number one issue leading to bigger outbreaks during the pandemic in for-profit homes.³³⁸

Recent studies in California and Connecticut have linked higher registered nursing staffing and hours to better outcomes for residents with COVID-19.³³⁹

- The California study found that long-term care facilities that did not meet the recommended hours of registered nursing care of 0.75 hours per resident per day, were twice as likely to have residents with COVID-19 infections.³⁴⁰
- The Connecticut study found that for long-term care facilities with at least one confirmed case, an increase of 20 minutes of registered nurse care per resident per day was associated with 22 per cent fewer confirmed cases. For homes with at least one death from COVID-19, each 20-minute increase of registered nursing care per resident per day was associated with a reduction in COVID-19 related deaths by 26%.³⁴¹

Registered nurses working in long-term care across Ontario report that their current staffing levels and workload are not safe, and must be addressed urgently:

- *“They have increased our existing impossible workload by adding more directives without increasing staff. One RN for 80 residents with multiple complex medical*

issues is unsafe. One RPN giving medications and treatments for 40 residents with multiple complex medical issues is unsafe!”

- *“Not enough staffing to provide safe and competent care to residents. Extremely short-staffing in RPNs has led to RNs completing double duty as RPN on unit and RN for building, which creates unsafe work. Short RN staffing as well, currently running building on five RNs without any casual relief staff.”*
- *“Our staffing issues came during the summer months, and continue. We worked short, one out of five nurses each weekend, with many nurses already working overtime. As charge nurse I informed management of unsafe working conditions and dangers.”*
- *“Poor staffing on floors such as a dementia unit is unsafe as these residents require regular monitoring, e.g. wanderers with dementia can easily spread the virus. Staffing should be increased on dementia units.”*

Addressing the Staffing Crisis: Recruitment and Retention

The Long-Term Care Staffing Study indicates that there are multiple reasons why registered nurses either avoid entering long-term care or leave the sector:

- **Pay:** The staffing study found that, on average, registered nurses working in for-profit and not-for-profit long-term care homes make less than registered nurses in the hospital sector and municipal long-term care homes.³⁴²
- **Precariousness of Employment:** The majority of registered nurses in long-term care work on a part-time or casual basis.³⁴³ More full-time jobs that offer stability and benefits are required to address retention issues.³⁴⁴
- **Workload:** Understaffing and leadership duties have combined to create impossible-to-meet workloads. This was a bad situation even before COVID-19. A 2019 report noted:
“The already low staffing levels are made worse by short-staffing, itself often the result of staff absences due to illness or injury resulting from the heavy workloads. It happens ‘almost every day and it’s not just RNs, it’s everybody.’ Working double shifts is common as a result, but it does not make up for all the absences. Such short-staffing is common and disruptive. It can mean nurses take on other work. ‘For us, when we’re short PSW staff, sometimes I am a PSW and then I’ll get people up... but also be in charge. But it’s not really the way it’s supposed to go.’”³⁴⁵



We didn't have the damn tools, they wouldn't give them to us, everything was reactive. –ONA member, anonymous interview with ONA counsel

- **Inadequate Training and Orientation:** Newly hired registered nurses have reported not receiving a proper orientation prior to starting their first shifts during the pandemic. In some cases, registered nurses simply quit within one or two first shifts because they were not adequately supported.
- **Organizational Culture:** In the ONA survey, many registered nurses expressed a deep mistrust of their supervisors. While these feelings existed before COVID-19, registered nurses felt that some employers unfairly blamed poor resident outcomes during the pandemic not on the systemic failings visible for all to see, but on staff. As reiterated in the Long-Term Care Staffing Study, the Gillese Report called for workplace cultures needing to shift from punitive environments to a “just culture – one in which human error is dealt with openly.”³⁴⁶

Time for Action on Adequate Staffing

The *Long-Term Care Homes Act* currently requires that there be one registered nurse on-site at all times. Early into the pandemic, regulations were passed which exempted long-term care homes from this requirement. More, not less staff is needed during an outbreak.

The one registered nurse minimum is wholly inadequate given the rising acuity levels of residents and range in resident capacity across Ontario, particularly during a pandemic.

Furthermore, as discussed in Chapter 5, this issue has been studied time and time again. Adequate staffing is essential to ensure that registered nurses can provide the care residents need and deserve.

It is time for action, not further studies.

Putting Safety First: The Hierarchy of Controls

The SARS Commission found that the hierarchy of controls, a fundamental concept in occupational health and safety, should be central to creating safe environments in all health care settings.

These controls, including engineering controls, administrative controls, and personal protective equipment, “are meant to address hazards through control at the source of a hazard, along the path

between the worker, and the hazard and lastly, at the worker.”³⁴⁷

Despite the SARS Commission report, and the recommendations of unions and worker safety experts, Ontario’s COVID-19 guidance to long-term care repeatedly failed to offer holistic guidance anchored in the hierarchy of controls.

Instead, the province granted broad discretion to nursing homes across Ontario to implement pandemic containment measures with little guidance or accountability.

A case in point was the failure to focus on engineering controls. The Ontario Society of Professional Engineers (OSPE) have called the Ontario Government to address “...the need for proper ventilation and air filtration to stop the spread of the virus via infected aerosol particles in the air.”³⁴⁸

Until recently, directives not only made no mention of ventilation systems, they also did not require health care organizations to proactively prepare pandemic plans, and update outbreak management or infection control policies. The directives also did not require a designated infection control practitioner to work with health care workers to prevent the transmission of COVID-19.

Registered nurses reported that employers did not treat COVID-19 with the seriousness merited for such a deadly virus:

- *“There was no signage, no teaching and I never saw infection control staff.”*
- *“They did not have a pandemic plan and ignored concerns about social distancing of residents.”*
- *“Memos sent for staff to read on some policies. No actual training though.”*
- *“The Administrator felt Corporate policies superseded Ministry directives.”*

What registered nurses, residents and other health care workers need is for employers to proactively implement engineering, administrative and other controls in advance of an outbreak, not during or after.

There is some movement at the federal and provincial levels.

On December 31, 2020, Public Health Ontario released an FAQ, *Use of Portable Air Cleaners and Transmission of COVID-19*. In this document, guidance states that “portable air cleaners equipped with a HEPA filter could remove COVID-19 virus particles from indoor air and potentially reducing exposure.”³⁴⁹

In January 2021, the Public Health Agency of Canada released guidance on indoor ventilation, acknowledging COVID-19 can be spread via respiratory particles created from breathing, talking, singing, shouting, coughing and sneezing.³⁵⁰

Building on these announcements, and looking to the future, measures to control airborne transmission need to be top-of-mind against both new pathogens, like COVID-19, whose transmission dynamics are little understood – and better-known pathogens, like influenza,³⁵¹ that new research suggests can also be spread through the air.

This is vital in long-term care, given many of the older buildings have inadequate and poor ventilation systems, the respiratory behaviours in the elderly population, and the close contact registered nurses have with residents.

Had proper controls been in place, at minimum, the severity of outbreaks might have been mitigated.

Personal Protective Equipment

Registered nurses reported case after case of being shamed in front of their colleagues by supervisors because they wanted to wear an N95 respirator, even though they had a right to request this protective equipment and the science showed it was warranted.

“I was intimidated,” said one registered nurse, who works at a home that experienced a severe outbreak. *“Management called in registered staff and chastised me in front of everybody for wearing an N95. I was told to wear a surgical mask and they shamed me in front of everybody in the room. Management then asked me, are you one of those people when you go out in public you wear a mask and gloves? I responded, absolutely.”*

In March 2020, another registered nurse, aware of the science and the precautionary principle but before masking was mandated, reported:



“I did start to wear one. As I put one on at the beginning of my shift, I was openly rebuked. Publicly shamed and scoffed at for wearing one. They told me to take it off as the employer did not have masks for the rest of the staff. I was also told I would be scaring the residents and what kind of a nurse was I to do that. This was said to me by the Infection Control Nurse and a member of Health and Safety, both of whom are RNs and my colleagues.”

It is unconscionable that registered nurses, with their training and expertise, should be shamed for wearing protective equipment meant to protect themselves and others.

Pandemic Preparedness

To paraphrase the great American writer Maya Angelou, when it comes to pandemic preparedness, long-term care operators should be: “Hoping for the best, prepared for the worst, and unsurprised by anything in between.”³⁵²

Instead, they have done the opposite.

The experience of SARS in Ontario served as a warning. It was not if, but when, a deadly novel virus would descend on Canada again.³⁵³ Justice Campbell knew that preparation was vital to avert another disaster.

As COVID-19 spread, too many long-term care homes did not have plans or precautions in place to handle what was to come.

There are stark differences between the experience of nurses that worked at homes that were prepared, and those that did not during the first wave, based on testimonials:

Prepared	Not Prepared
<p><i>“Proper screening at the front door, proper PPE usage for staff, shutting doors to units, keeping staff contained on the infected unit, lots and lots of available hand sanitizers as well as use of masks. Social distancing as appropriate, lots of education on infection control as needed.”</i></p>	<p><i>“I experienced high anxiety while working at the LTC facility. My anxiety was related to working in an unknown facility that was grossly understaffed and I found myself responsible for the care of 30 – 60 residents. I was not prepared to be the “charge nurse” on a night shift during my second or third day, and I was most certainly not prepared to administer medication and provide care for 33 residents, ALL ALONE, on my second day...”</i></p>
<p><i>“The Joint Health and Safety Committee increased meetings to bi-weekly and the worker representatives felt heard. The employer listened to any concern from staff and took action to address those concerns. Communication during the pandemic has been fantastic. There was communication daily from management in person, at every shift change, to ensure that everyone was aware of any changes to direction and policy... I wish I could say my experience was the experience of other RNs across this province, but it is not. Other employers were not proactive, which caused serious illness and death in their homes.”</i></p>	<p><i>“Never worked under circumstances like this. It felt like a terrible nightmare. We started the day with a prayer for all of us. Never knew if we are going to finish the shift and how many of us will be still alive. Our second family/resident were dying from this terrible virus in large numbers. Never seen this many people dying. There were and still are horrible nightmares and sleepless nights and death all around. Nobody seemed to care or willing to help. We were counted as collateral damage – dismissed easily...”</i></p>
<p><i>“We did proactive plans for infection control, we did have lots of suspect outbreaks but every resident has been tested and swabbed and they all came out negative, we never had any residents who were tested positive for COVID.”</i></p>	<p><i>“Residents were kept in the same place where they were. There was no plan, so no action. Hard work without a plan was useless. There was no properly trained infection control person to lead and there was a lack of teamwork, which led to a poor result.”</i></p>

Going forward, long-term care facilities must be required to develop pandemic plans, to update them annually, to train staff on them, and to have annual exercises to test the facility’s pandemic preparedness. Pandemic plans and preparedness should be audited annually by the province.

The province should also ensure that long-term care facilities have the latest information on the evolving science on infectious disease transmission and control, and pandemic planning and response best practices, and that pandemic plans benefit from the expertise of occupational health and safety experts, like hygienists. Government oversight is needed to ensure homes are investing the necessary time and resources to plan for public health emergencies.

Accountability

The strength of inquiries like the SARS Commission and the Long-Term Care COVID-19 Commission (LTC Commission) is that they are able to yield vital insights into the root causes of a public health emergency and how it can be prevented.

The weakness of such commissions is that no one is held accountable.

Inquiries like the SARS Commission and the LTC Commission follow an approach pioneered in transportation safety investigations intended to ensure that root causes are thoroughly investigated and understood.



I feel helpless to help my residents and co-workers. I don’t think I will ever recover from this. –ONA member, survey response

As the investigation into the Columbia space shuttle disaster in 2003 explained:

“With a principal focus on identifying and correcting threats to safe operations, safety investigations place a premium on obtaining full and complete disclosure about every aspect of an accident, even if that information may prove damaging or embarrassing to particular individuals or organizations. However, individuals who have made mistakes, know of negligence by others, or suspect potential flaws in their organizations are often afraid of being fired or even prosecuted if they speak out.”³⁵⁴

In his final report, Justice Campbell alluded to the fact that some health leaders failed to learn from SARS, despite their own mistakes:

“Some of the same Ontario hospital leaders who argued against the N95 respirator required to protect nurses and who actually denied there was a safety law that required the N95 to be fit tested still insist that science, as it evolves from day to day, comes before safety. If the Commission has one single take-home message it is the precautionary principle that safety comes first, that reasonable efforts to reduce risk need not await scientific proof. Ontario needs to enshrine this principle and to enforce it throughout our entire health system.”³⁵⁵

No one was held accountable for the failures of SARS. While many public health leaders, like the late Dr. Sheela Basrur and the late Dr. Donald Low, acted heroically during SARS, not everyone acted as commendably.

The problem is that, in the wake of SARS, all health leaders – regardless of how well or poorly they performed – were able to burnish their CVs with their SARS experience. The lack of accountability meant that everyone was treated as a hero, whether they deserved it or not.

Which brings us to COVID-19.

Registered nurses feel there needs to be accountability. As one said:

“I believe there should be accountability and I feel that management at my facility will not be accountable because the facility that appears to have less COVID deaths of residents than us are in the limelight but not us. We need to talk about what went wrong and what could have been done...”

There were widespread reports that medical directors, particularly during the first wave, were not attending the home in person.

One registered nurse recalls that, *“the workload increased exponentially during the worst times. Doctors, NPs, other medical allied providers all stopped going to the facility, therefore all assessments had to be done solely by the nurse.”*

The experiences of registered nurses during COVID-19 have created deep feelings of “anger, frustration, fear, and a sense of violation that may have long-lasting implications.”³⁵⁶ They have expressed distrust towards their employers. In some circumstances, nurses have left long-term care and have not looked back.

“I will not work in LTC again,” said a respondent to the ONA survey, *“I have never worked in a place where I feared so much for my residents and my license. It was a very disrespectful experience.”*

Another registered nurse said: *“I had no power and all the accountability.”*

There is a gap in our system of investigating public health emergencies. Inquiries like the SARS Commission and the LTC Commission have the ability to investigate what went wrong and how to fix it. What is missing from their mandates is the equally important matter of accountability.

The absence of accountability can have serious consequences in health care. As Dr. Ted James, a surgery professor at Harvard Medical School, noted, an absence of accountability in health care

*“...sets a dangerous precedent as people start to learn that there are no real consequences for poor behaviour or performance. Without accountability, engagement wanes and resentment can build...”*³⁵⁷

If nothing is done on accountability, registered nurses and other health care workers, who themselves are being held accountable – together with the victims of COVID-19 and their families and communities – may further lose trust in government and its ability to protect society’s most vulnerable.

Toxic Work Culture

Mistrust poisons any work environment. Doubly so in long-term care before COVID-19. Exponentially so since the start of the pandemic.

The absence of trust has been the subject of significant organizational research. As management consultant Rey Castellanos has noted:

“Trust is the foundation of all successful teams and the absence of trust is a billboard on the road to dysfunction. Teams that don’t trust each other assume negative intentions, dread spending time together, and don’t ask for help from each other.”³⁵⁸

Many registered nurses might argue (with good reason) that long-term care during COVID-19 is well past the “billboard on the road to dysfunction.”

“I lost trust in the management,” said one nurse in long-term care. *“One example is they wanted us to use dust masks instead of surgical masks during the first outbreak. They were not fair or consistent with all staff. They have made numerous payroll mistakes that have taken months to fix. Big lack of support.”*

“I do not trust the administration, public health and minister of health and LTC,” added another nurse.

Along with mistrust, many registered nurses reported a lack of supportive leadership in long-term care:

- *“Relationships with my managers were strained as they did not provide any support; managers would not heed staff feedback on concerns during the pandemic.”*
- *“The stress came with working short-staffed, managers were unhelpful with supporting the floor. PSWs really resented them. It was frustrating to report to management suggestions and ideas and not receive any feedback. Management’s wording was always negative – i.e. forcing PSWs to stay on for four more hours.”*
- *“I worked a ton of overtime. I voluntarily went in unpaid for three hours on my day off to do a phone consult with a specialist for my high risk behavioural residents to ensure they were properly medically managed. When I asked for a day off once I became exhausted, burnt out, having mental fatigue, my manager (who made sure she took her days off) denied my request because they didn’t want to pay overtime to cover me....”*
- *“Managers ran and hid during the pandemic and were never seen.”*

Another symptom of the dysfunction in long-term care is the absence of collaboration with registered nurses, an absence that was a recurring theme during COVID-19.

Mistrust, the absence of supportive leadership and a resistance by management to collaboration are hallmarks of poorly functioning organizations. That these qualities are found across the long-term sector – and not confined to a few outliers – suggests that this is a systemic issue. Systemic problems require systemic solutions.

Without systemic solutions, workplace culture in long-term care will remain problematic, negatively impacting resident care and the ability to attract and retain the best and brightest registered nurses and other health care workers.

These organizational problems in long-term care extended to health and safety, including the internal responsibility system.

According to the Ministry of Labour, the internal responsibility system

“...means that everyone in the workplace has a role to play in keeping workplaces safe and healthy. Workers in the workplace who see a health and safety problem such as a hazard or contravention of the *OHSA* in the workplace have a statutory duty to report the situation to the employer or a supervisor. Employers and supervisors are, in turn, required to address those situations and acquaint workers with any hazard in the work that they do.”³⁵⁹

Clearly, during COVID-19, registered nurses and ONA did their duties under the internal responsibility system; employers in long-term care did not.

It is vital that Ontario moves urgently to fix this important system in long-term care.



Part 2 – Perspectives on Transforming Long-Term Care: The Role of Government

Accountability in CMOH Decision-Making

Perhaps the most troubling decision of COVID-19 was the March 2020 decision by the Chief Medical Officer of Health, Dr. David Williams, to downgrade precautions for health care workers.

In so doing, Dr. Williams said he considered the precautionary principle, as required under section 77.7(2) of the *Health Protections and Promotions Act (HPPA)*, but claimed on the basis of extremely limited evidence, that Ontario had definitively concluded that COVID-19 did not spread through the air.

This was a bad decision. It was poorly considered, and poorly executed. It was a decision that led to preventable death and disease – because health care workers were not sufficiently protected, and Ontario delayed other protective measures against airborne transmission, such as ventilation and air purification.

At the time when the decision was made, there was already sufficient evidence about airborne transmission to warrant a precautionary approach. Dr. Williams disregarded it. The evidence has subsequently grown to such an extent that there is now a consensus that airborne transmission is a major route of transmission for COVID-19. Ontario still has not acted.

A decision of this magnitude, with such profound consequences, cannot be taken without transparency and accountability.

The *HPPA* must be amended to:

- Make the precautionary principle a mandatory principle to be applied, and not something to be merely considered;
- Detail the evidentiary basis required to support any decision stating that the precautionary principle is not needed, and worker safety precautions can be lowered;
- Require any decision to downgrade precautions, and say the precautionary principle is not needed, to be the subject of legislative hearings where the CMOH would have to publicly explain and defend his decision;
- Require any decision to downgrade precautions to be reviewed on an emergency basis within 15 days to ensure it's an appropriate course of action; and
- Require the decision to be evaluated by the Auditor General of Ontario.

Whistleblower Protection

In an echo of SARS, many registered nurses were afraid of retaliation if they spoke publicly about hazards in long-term care to residents and staff.

“Employers have been using fear to silence the voice of the employees who advocate for those unable to voice concerns themselves,” said one registered nurse.

Justice Campbell was very concerned that the freedom of health care workers to warn about public health risks was stifled by a lack of whistleblower protection:

“Ontario health care workers need whistleblower protection to ensure that public health risks are reported promptly to public health authorities without fear of consequences. Without this protection, fear of workplace consequences might discourage the timely disclosure of public health risk. Front line health care workers made enormous sacrifices during SARS. They are entitled to be protected when they raise an alarm to protect public health.

As one nurse told the Commission: *“I want to have the freedom to speak out, so that I'm not worried I might lose my job.”*

Nurses and other health care workers should be able to alert public health authorities to infection control and disease outbreak problems within hospitals, nursing homes, and the like. If instruments are not being properly sterilized, if a hospital is not actively investigating reports of a possible infectious outbreak, health care workers should be able to report it to public health officials without fear of personal consequences. Workers who disclose information vital to protecting the public's health should be assured that they are protected legally against any form of employer reprisal or workplace consequence.”³⁶⁰

In her October 20, 2020 report on COVID-19, Ontario's Patient Ombudsman revealed that her office had received a number of complaints from staff about long-term care conditions. Many, she indicated, were afraid of retaliation:

“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 organization who employed them.”³⁶¹

A 2020 report from the Patient Ombudsman identified that a large number of anonymous complainants appeared to be long-term care home staff.³⁶² These anonymous complainants communicated that they were fearful of “negative impacts to their job or standing at work” as a result of making a complaint.³⁶³

The SARS Commission recommended that health care workers need to have explicit whistleblower protections in the *Health Protection and Promotion Act*, with the following principles:

- “It applies to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;
- It enables disclosure to a medical officer of health (including the Chief Medical Officer of Health);
- It includes disclosure to the medical officer of health (including the Chief Medical Officer of Health) of confidential personal health information;
- It applies to the risk of spread of an infectious disease and to failures to conform to the *Health Protection and Promotion Act*;
- It prohibits any form of reprisal, retaliation, or adverse employment consequences, direct or indirect;
- It requires only good faith on the part of the employee; and
- It not only punishes the violating employer but also provides a remedy for the employee.”³⁶⁴

Changes to whistleblower protections not only need to protect workers from reprisal in the employment context, it must also protect workers from regulatory consequences.³⁶⁵ In Ontario, there is no express provision in the regulatory standard of registered nurses that encourages whistleblowing as part of their duty to advocate for quality patient care.

Clear Government Direction

Ontario issued many directives, orders, guidance documents, reference documents, memos and documents with “frequently asked questions.” Many of these documents were revised within days of their original

release. The authors of these documents included the Ministry of Health, Ministry of Long-Term Care, Public Health Ontario, the Chief Medical Officer and Ontario Health. This does not include guidance provided by a home’s local public health unit.

While guidance and direction are necessary during a pandemic, the release of information appeared to be chaotic and conflicting between documents released by various departments.

“I find the government directives are confusing and change too often,” said one nurse.

Another nurse said, *“It has certainly been a challenge, changes were frequent and sometimes caused confusion...”*

During a pandemic, government needs a clear communication strategy that is able to convey vital information, not sow confusion.

The For-Profit Dilemma

Ontario has a higher proportion of for-profit homes than any other province in Canada, accounting for about 58 per cent of total ownership. In Canada as a whole, for-profits account for 28 per cent overall ownership.³⁶⁶

Current statistical information on infection and mortality rates suggests that outbreaks in for-profit homes are worse.³⁶⁷

Research has found for-profit homes commonly operate out of buildings that are poorly designed to limit the spread of infections.³⁶⁸

The *Toronto Star* reports that the three largest publicly traded long-term care operators – Extendicare, Sienna Senior Living and Chartwell Retirement Residences – paid out more than \$171 million to shareholders during the first three-quarters of 2020. This at the same time they were receiving \$138.5 million in government funding.³⁶⁹

CBC’s *Marketplace* found that for-profit homes had higher average rates of death – 5.2 deaths per 100 beds – than non-profits (2.8) or municipal homes (1.4).³⁷⁰

A registered nurse working in a for-profit home stated, *“They have been understaffed, and not listened to. The leaders are all about cutting costs and not about safety and the residents. I do like working in this environment; however, a lot of improvements are required.”*

Another registered nurse noted that her for-profit home said, “*There is no budget for lifts, laptops or shower chairs.*”

“*I have worked there for 20 years,*” added a registered nurse at a for-profit home who caught COVID-19 at work. “*Ownership changed three times... Every change came with more cuts, cuts, cuts. More for-profit meant cutting the budget and cutting staff.*”

For-profit ownership of a home in Canada is associated with inferior resident care.³⁷¹ Research has found that for-profit homes provide less resident care hours and employ fewer registered nurses than not-for-profit homes.³⁷² Prior to COVID-19, residents in for-profit homes were statistically more likely to experience higher rates of hospitalization and mortality.³⁷³

Ontario research has suggested that for-profit homes favour hiring lower-cost labour, such as registered practical nurses and personal support workers, over registered nurses.³⁷⁴

The Science Table acknowledged that for-profit homes have experienced almost double the amount of infected residents and 78 per cent more deaths compared to not-for-profit homes.³⁷⁵

“What’s the benefit of having for-profit long-term care, that is primarily funded by government, primarily regulated by government? What is the benefit? I don’t see the benefit,” said Pat Armstrong, long-term care expert at York University in Toronto.³⁷⁶

Registered nurses have advocated for governments to eliminate for-profit ownership and transfer ownership to not-for-profit owners or municipalities. The opposition NDP has put forward a plan to convert the sector to public ownership.³⁷⁷

At a minimum, registered nurses believe that conditions should be placed on public funding for long-term care operators, whether for-profit or not-for-profit. Every dollar a long-term care home receives from the government and from co-payments should be directed toward improving the conditions of the residents and not towards profits.

Measures should be put in place to prevent for-profit operators from doing what the *Toronto Star* reported – paying millions to shareholders while pocketing millions from government.

Profits in the sector should also be regulated, so that residents and health care workers are the priority for any funds destined for shareholders.

It is troubling that while staffing and other problems intensified in long-term care, the three largest for-profit nursing home operators in Ontario paid out \$1.5 billion in dividends to shareholders over the last decade, the *Toronto Star* reported. This total did not include \$138 million paid in executive compensation and \$20 million in stock buybacks (a technique that can boost share prices).³⁷⁸

One wonders what a difference to the pandemic response those \$1.5 billion would have made, had they been spent wisely and appropriately on residents and health care workers.

Ministry of Long-Term Care Inspections and Enforcement

With regards to the Ministry of Long-Term Care enforcement powers, the *Toronto Star* reported:

“While the *Long-Term Care Homes Act* allows for the laying of provincial offences charges, the ministry says it is aware of just one case where a home was charged. In that case, from September 2017, a home was charged for failing to immediately report suspicion of ‘certain matters’ to the director, including abuse or neglect of a resident. But the charges were later withdrawn for having no reasonable prospect of conviction.”³⁷⁹

It is no wonder that one critic said the Ministry’s “...inspection branch is so weak that the law is literally unenforceable.”³⁸⁰ The CBC reported that a total of 85 per cent of Ontario nursing homes were repeat offenders of breaching the standards under the *Long-Term Care Homes Act*.³⁸¹

Of these repeat offenders, one facility had 289 infractions between January 1, 2015 and December 31, 2019, more than any other facility in Ontario.³⁸²

History has shown that an absence of enforcement frequently leads to an absence of compliance. As an American expert on the culture of compliance has noted:

“If the law imposes the right mix of detection and sanctions, firms will for that reason alone have an incentive to take steps to reduce legal risk... The public benefits from precautionary investments



Three to four staff were taking care of 72 residents, which was an impossible task.

—ONA member, survey response

in legal compliance that minimize the net social costs of law violations committed by agents of the corporation. A socially optimal compliance program, then, can be defined as what ‘a rational, profit-maximizing firm would establish if it faced an expected sanction equal to the social cost of the violation.’”³⁸³

Absent an effective enforcement regime at the Ministry of Long-Term Care, long-term care operators have no incentive to take the steps necessary to reduce their legal risk.

What is needed is an enforcement regime with the teeth to ensure the prospect of violations creates the right salutary lesson.

Ministry of Labour

The role of the Ministry of Labour is to ensure that workplaces are aware of and in compliance with worker safety standards.

The Ministry failed to fill that role during SARS and has a similar record during COVID-19.

One nurse said: *“Whenever I think of the number of residents who died I become so angry. This was preventable but I couldn’t get anyone to listen – not management, not the MOH and not the MOL!”*

A case in point occurred in a meeting between an ONA representative and a Ministry of Labour inspector who declined to issue orders on personal protective equipment because he claimed the Ministry did not have jurisdiction:

“ONA Representative: We are expecting our nurses to have appropriate PPE. Our nurses are at risk.

Inspector: No, no that is Ministry of Health direction, I won’t cross that.

ONA Representative: Will you or will you not write orders?

Inspector: The issue is surgical masks versus respirators; Ministry of Labour doesn’t have jurisdiction.”

The Ministry of Labour did have jurisdiction to issue orders but opted not to exercise its authority. In addition to enforcement, the Ministry has a second equally important responsibility. As Justice Campbell explained in the SARS Commission report, a workplace regulator

“...must be responsible for the development of worker safety standards that reflect the latest scientific research, occupational health and safety expertise and best practices, and the standards recommended by other agencies, such as the National Institute for Occupational Safety and Health (NIOSH).”³⁸⁴

Instead, the Ministry is relying on Ministry of Health guidelines. A Ministry of Labour spokesperson said:

“...inspectors rely on ‘ministry of health guidelines to inform their decision on whether employers are adequately protecting workers from contracting the virus.’”³⁸⁵

One reporter even had the experience of the Ministry of Labour deferring to the Ministry of Health for comment on a matter well within Labour’s jurisdiction:

“Staff at the Ministry of Labour referred the *Star* to the Ministry of Health when asked if [Ministry of Labour] occupational health and safety teams were involved in the coronavirus preparation and containment strategy.”³⁸⁶

COVID-19 has demonstrated that the worker safety lessons of SARS have not been learned.

In his final report, Justice Campbell wrote:

“The Ministry of Labour must be independent in setting workplace standards and in enforcing them. It must be an integral member of the response to any infectious disease outbreak. It must be directly involved in any post-event review of any infectious disease outbreak in which workers have gotten sick. Any post-event review of an infectious disease outbreak in which workers have gotten sick must include worker safety experts.”³⁸⁷

Successive governments have failed to implement his recommendations on the Ministry of Labour. The Ministry of Labour's inaction during COVID-19 repeated its failure to take a leadership role on worker safety during SARS. It is vital that those reforms be undertaken now on an urgent basis.

Investing in Better Infrastructure

Long-term care homes that remain at the 1972 standard are known as C- and D-level structures.

C- and D-level structures contain ward beds that may allow up to four residents per room. One nursing home that contains a mix of semi-private and ward rooms is described as follows:

“Residents in the semi-private and four-bed rooms are separated by a curtain. The first two beds are across from one another with no wall. The beds are approximately three feet apart from each other. There are only curtains that can be drawn across a bed. The entrance to these rooms is big and open. All residents share this entrance. The residents in semi-private and four-bed rooms also share a bathroom that is located at the entrance of each room.”

Research by CBC's *Marketplace* found a troubling correlation between severe outbreaks and homes that have not been upgraded from these 1972 building standards:³⁸⁸

“Only a third of the 78,163 beds in Ontario facilities remain at the 1972 standard, referred to as C, but they account for 57 per cent of the province's 1,691 reported COVID-19 deaths (as of Tuesday morning) in long-term care homes.

Buildings that operate at the C standard may have four-person shared wards and communal dining rooms where hundreds of people are brought together for meals.”³⁸⁹

Subsequent studies have tied the severity of outbreaks to overcrowding, older design standards, poor ventilation, and for-profit chain ownership.³⁹⁰

By March 29, 2020, 37.3 per cent of residents were living in a semi-private room and 25.8 per cent living in a ward beds.³⁸⁹ To determine the impact of crowding on the spread of COVID-19, researchers defined a crowded home by calculating the average number of residents

divided against half the number of beds and half the number of bathrooms in the facility. As of May 20, 2020, homes defined as highly crowded had:

- A COVID-19 infection rate of 9.7 per cent while less crowded homes had an infection rate of 4.5 per cent.
- Mortality rates were 2.7 per cent for highly crowded homes and 1.3 per cent for less crowded.
- Crowded homes also saw 90 per cent of outbreaks that had more than 100 infected residents.

This research did not indicate the proportion of ownership among the crowded homes.³⁹²

Simulations run with available data suggested that 19.1 per cent (998) of infections and 18.1 per cent (263) of deaths could have been prevented if quadruple-bed rooms had been converted to semi-private. If all rooms had been converted to a private room, the simulations estimated 31.4 per cent (1,641) of infections and 30.1 per cent (437) of deaths could have been prevented.³⁹³

When the new safety standards were implemented in 1998, mandating, among other things, that bedrooms should house no more than two residents,

“Homes that didn't meet the new standard were allowed to keep running as-is, with an expectation they would upgrade eventually. The vast majority of homes that haven't yet upgraded are run by for-profit companies.”³⁹⁴

Twenty-two years after the new standards were implemented, it is essential that this be rectified on an urgent basis. Ward rooms are no longer an acceptable living arrangement to control infections. They are simply unsafe in the context of an outbreak of a deadly virus.

A “Made in Ontario” NIOSH

Canadian companies developing new types of respirators have to go to the National Institute for Occupational Safety and Health, better known as NIOSH, in the U.S., to get them certified. Ontario does not have a NIOSH-equivalent certification entity. The process was not rapid because NIOSH “was prioritizing U.S. applications.”

Ontario's ability to try and dig itself out of its personal protective equipment shortages was thus hampered by the absence of a significant domestic regulatory capability.

The province could have had such a capability had it implemented Justice Campbell's recommendation to establish our own NIOSH:

- That just as NIOSH, the main U.S. federal agency responsible for worker safety research and investigation, is part of the Centers for Disease Control and Prevention (CDC), so the Ontario 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.
- That any section of the Ontario Agency for Health Protection and Promotion involved in worker safety has, as integral members, experts in occupational medicine and occupational hygiene, and representatives of the Ministry of Labour, and consult on an ongoing basis with workplace parties.
- That the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety.
- That the Ontario Agency for Health Protection and Promotion ensure that it becomes a centre of excellence for both infection control and occupational health and safety.

- That the mandate of the Ontario Agency for Health Protection and Promotion include research related to evaluating the modes of transmission of febrile respiratory illnesses and the risk to health workers. This research should also identify the hierarchy of control measures required to protect the health and safety of workers caring for patients with the respiratory illnesses.³⁹⁵

National Standards for Long-Term Care

The *Canada Health Act*³⁹⁶ does not set any preconditions for the transfer of federal funds for long-term care homes to the provinces.

Some have argued that federal legislation and leadership could be the key to lifting standards so that seniors obtain the same basic level of care across Canada.³⁹⁷

National funding based on compliance with national standards of care, with transparency, are essential to implement policies and practices that foster safety and health in long-term care homes.³⁹⁸

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Chapter 10

Conclusion

10

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Introduction:

Part 1: Hubris vs Humility

“Life is a long lesson in humility.”

–Author J.M. Barrie

The word “hubris” is often defined as exaggerated self-confidence.³⁹⁹ It came into the English language from classical Greece:

“English picked up both the concept of hubris and the term for that particular brand of cockiness from the ancient Greeks, who considered hubris a dangerous character flaw capable of provoking the wrath of the gods.”⁴⁰⁰

The opposite of hubris is humility,⁴⁰¹ a quality increasingly seen as an important leadership trait.

“A sense of humility is essential to leadership because it authenticates a person’s humanity,” said an article in the *Harvard Business Review*. “We humans are frail creatures; we have our faults. Recognizing what we do well, as well as what we do not do so well, is vital to self-awareness and paramount to humility...”⁴⁰²

Research has validated the value of humility in effective leadership:

“A number of research studies have concluded that humble leaders listen more effectively, inspire great teamwork, and focus everyone (including themselves) on organizational goals better than leaders who don’t score high on humility.

Case in point: A survey of 105 computer software and hardware firms, published in the *Journal of Management*, revealed that humility in CEOs led to higher-performing leadership teams, increased collaboration and cooperation and flexibility in developing strategies.”⁴⁰³

Humility is also seen as an important trait in medicine.

Writing in the *Mayo Clinic Proceedings*, Dr. James T.C. Li, a Mayo Clinic faculty member, stated:

“Physicians are complex creatures that defy categorization and generalization. The picture of the cold, clinical, aloof physician may be only a caricature. (Surely such physicians do not actually exist!) Sometimes, however, our unstated, unchallenged tendencies are even more dangerous than extremes in behavior.

The self-centered, physician-centered doctor *tends* to discount the patient’s point of view, *tends* to overestimate his clinical skills or fund of knowledge, and *tends* to respond poorly to instruction.

In contrast, the humble physician *tends* to understand the patient’s point of view, *tends* to recognize opportunities for improvement, and *tends* to embrace lifelong learning.”⁴⁰⁴

Echoing those sentiments, Dr. Jack Coulehan, writing in the *Annals of Internal Medicine*, stated:

“Perhaps the most difficult virtue to understand and practice is humility, which seems out of place in a medical culture characterized by arrogance, assertiveness, and a sense of entitlement. Countercultural though it is, humility need not suggest weakness or lack of self-confidence. On the contrary, humility requires toughness and emotional resilience.

Humility in medicine manifests itself as unflinching self-awareness; empathic openness to others; and a keen appreciation of, and gratitude for, the privilege of caring for sick persons. Justified pride in medicine’s accomplishments should neither rule out nor diminish our humility as healers.”⁴⁰⁵

The precautionary principle is the embodiment of humility. In the face of a new pathogen like COVID-19, it advises: Let’s be careful; let’s be cautious; let’s err on the side of safety; let’s not assume we know everything; let’s not be over-confident in our knowledge or our abilities.

The precautionary principle – and by extension professional humility – are in the DNA, training, and approach of registered nurses.

Early in the pandemic, the eminent American health care worker safety expert, Lisa Brosseau, advised public health and infectious disease leaders to be humble and take a precautionary approach:

“It’s OK to say that we’re still gathering evidence... Infection prevention, medical and public health professionals should be communicating to everyone that the exact modes of transmission for SARS-CoV-2 – the technical name of the virus that causes COVID-19 – are unknown. There are no studies, yet, to support any particular mode of transmission over another.”⁴⁰⁶

Brosseau’s comments were published on March 16, 2020.

Consider what was happening at around this time in Ontario in the context of the continuum between humility and hubris.

On January 24, 2020, for example, Dr. David Williams, the Chief Medical Officer of Health, assured Ontarians that the province

“...are better prepared because of the SARS experience. Through SARS and through all the work later, we have set in place standard policies and procedures... We’re light years ahead of where we were in 2003.”⁴⁰⁷

The reality was quite different. The tragic levels of death and disease of COVID-19 would demonstrate that Ontario was not prepared.

That same day, Dr. Peter Donnelly, President and CEO of Public Health Ontario, dismissed the possibility that Ontario would experience the type of massive lockdowns then being implemented in China, suggesting that

“...scary images coming from a now isolated Wuhan, a Chinese city with 11 million people, will not be repeated here.

‘Absolutely not,’ Dr. Peter Donnelly with Public Health Ontario said. ‘If a case comes here, and it is probably likely that we will have a case here, it will still be business as normal.’⁴⁰⁸

This belief – that the worst of China’s initial COVID-19 experiences could not be repeated in Ontario – was not uncommon. Some have seen it as an example of Western exceptionalism. Dr. Richard Horton, editor of *The Lancet*, explained:

“There was a general skepticism combined with exceptionalism. We thought our health systems are better. Our scientists are better. Our doctors are better. And we will be able to handle this better than the Chinese have done. This is why tens of thousands of our citizens died, and they didn’t need to die.”⁴⁰⁹

On March 10, 2020, Dr. Williams claimed, despite extremely limited evidence on COVID-19’s transmission dynamics, that COVID-19 did not spread through the air, that the precautionary principle could be safely discarded, and that health care workers did not need airborne protections.

At the time, there was plenty of evidence from China – together with warnings by Dr. Brosseau, the Ontario Nurses’ Association (ONA), and many others – that a precautionary approach was warranted.

Yet, over and over, public health and infectious disease leaders claimed – despite mounting evidence – that they were certain that COVID-19 could not spread through the air.

In a letter to the *Toronto Star* in May 2020, punctuated by claims that those who argued for the precautionary principle added “fuel to fire,” some of the province’s top infectious disease specialists stated:

“If COVID-19 were an airborne infection, physical distancing rules would not be effective and we would see large and widespread outbreaks in places adhering to droplet prevention, including hospitals. We have not.”⁴¹⁰

That there is now a consensus that COVID-19 spreads through the air validates the importance of the precautionary principle – and of humility. It also serves as a warning about the dangers of hubris in pandemic response.

Humility was an important lesson of SARS. As one unidentified physician told the SARS Commission:

“Answer: I think what SARS did is it humbled us and it also made us realize that even when we think we know everything, we don’t. And that diseases can, the changing nature of disease emerges gradually, and we have to be very attuned to the clues that come from the ground up, not necessarily from the top to the bottom so I think humility makes the better nurse and doctor. I would always err on the side of caution.

Question: And that applies to protective equipment?

Answer: Yes, until they’re...it’s very difficult. We were told there’s absolutely nothing to worry about and then we did have something really to worry about, so I don’t know when one can ever relax, but I would, as I said, I would err on the side of caution and use the most protective equipment I could until I had an absolute assurance that a modification was safe. Especially if you’re dealing with someone’s life.”⁴¹¹



Whenever I think of the number of residents who died I become so angry...this was preventable but I couldn’t get anyone to listen. –ONA member, survey response

Fast forward to COVID-19, and there are again examples of thoughtful doctors pointing to the importance of humility.

“This is a very stealthy pathogen,” said Dr. Steven Gordon of the Cleveland Clinic in the U.S. “It has taught us a lot of humility.”⁴¹²

But probably the most compelling validation of the importance of humility came from Dr. Anthony Fauci, the top American infectious disease expert.

In September 2020, he delivered a lecture at Harvard Medical School, stating:

“We really got to realize that from day one, you don’t know it all. And you’ve got to be flexible enough to change your recommendations, your guidelines, your policies, depending upon the information and the data that evolves. Because, if you look at what we knew in February compared to what we know now, there really are a lot of differences that are there right now – the role of masks, the role of aerosol, the role of indoor vs outdoor, you know, closed spaces. You’ve just got to be humble enough to realize that we do not know it all from the get-go and even as we get into it.”⁴¹³

Dr. Fauci’s final comments are worth repeating: “You’ve just got to be humble enough to realize that we do not know it all from the get-go and even as we get into it.”

If there is a single COVID-19 message for the public health and infectious disease communities – a message delivered over and over by registered nurses, ONA, and worker safety experts, all steeped in the precautionary principle – it is that, in responding to a public health emergency, humility and the precautionary principle, not hubris, should guide their actions.

Part 2: A Better Way

Some Ontarians may look at Hong Kong, Taiwan, and South Korea with envy, and wish our long-term sector had been as effective in protecting our seniors.

In fact, there’s an equally impressive example of pandemic containment excellence closer to home: Mariann Home, a non-profit, 64-bed facility in Richmond Hill, north of Toronto.

None of its residents tested positive. One staff member tested positive but was not the source of any spread in the facility. What makes this so remarkable is that Mariann Home is an old “C” facility rescheduled for development in 2025. It has one ward room with four residents. The rest of its residents are in semi-private rooms.

The CEO and Administrator, Bernard Boreland, described the key measures that Mariann Home took to prevent COVID-19 from coming into the facility:

“I would say that the key areas for success for us during this entire ordeal...were early planning; communication, especially with the families and our employees; leadership, very important; the administration team as well as infection control practices.”⁴¹⁴

Mariann Home also took a precautionary approach to the possibility of airborne transmission. Erly Valera, its Director of Care, told the Long-Term Care COVID-19 Commission (LTC Commission):

“Because we know that COVID is airborne...we converted our residents that are receiving the... oxygen humidity test into puffers...it doesn’t spread in the room.”⁴¹⁵

Where personal protective equipment shortages have plagued most long-term facilities, Mariann Home has had a plan for the past 10 years to ensure, at year end, that they have enough supplies for the coming year. With respect to N95 respirators, Mariann Home regularly topped up its supply due to its mask fit-testing program that had been in place for the past eight years.

As the outbreak was gathering momentum in the first quarter of 2020, Boreland told the Commission:

“...January 20th...our PPEs were in very good shape because...I just did my year-end top-up, so we had all of the appropriate N95s and surgical masks.”⁴¹⁶

“I made some calls to my suppliers in February...that’s when they told me that we could expect a shortage of PPE supplies in March and April. So we continued to order the necessary supplies we needed.”⁴¹⁷

In the second week of March 2020, Mariann Home implemented universal masking for its staff, and had the supplies to properly equip staff. This was prior to the public health direction to universally mask issued by the Chief Medical Officer of Health almost one month later on April 8, 2020.⁴¹⁸

Boreland explained to the Commission his vigilance to take extra precautions:

“In March when things are going crazy, I walked the floors constantly looking for safety measures and how we can improve the facility. It was the second week of March that we implemented the universal face masking for all of the staff.”⁴¹⁹

“I was able to provide them with the appropriate PPEs for the bus. So gloves and masks, we supply that on a two-week basis for all of those staff.”⁴²⁰

Staffing has been an issue at many long-term facilities. But not at Mariann Home, which addressed staffing concerns early in COVID-19, before they were allowed to fester.

Boreland stated:

“Another thing that was very, very key in our success was the single-employer rule...we implemented that before the Ministry mandated it...”⁴²¹

“I personally spoke to all of my good part-time employees and basically told them that if they chose Mariann Home, that I would give them full-time work until the conclusion of this pandemic...so that’s one of the reasons why...we weren’t in the staffing crisis that a lot of these other homes were in, because we were able to tackle it early...”⁴²²

Over and over, Boreland’s testimony highlighted what was possible to contain COVID-19 and what other long-term care providers – especially those operated by deep-pocketed corporations – should have done but did not.

On pandemic preparedness:

“In January, we also got all of our pandemic plans in order. The dietary department ensured that they had three months of paper supply in place. We also introduced – or created a pandemic menu for the residents just in case we were to go down in staff or if we had any supply issues. So, all of that was developed in January and February.”⁴²³

On designation of isolation rooms:

“That’s something that we looked at in the very beginning of this pandemic. If COVID were to get in here, where would we isolate the residents? So, we did say that we would use our activation lounge on each floor if that were to happen. So, we use the lounge on each floor as our isolation room.”⁴²⁴

On an emphasis on infection control, Boreland stated:

“We continue to do PPE and hand hygiene audits on a daily basis.”⁴²⁵

“...very seasoned director of care, 40-plus years in the industry...around during the SARS days, so she knows everything about infection control.”⁴²⁶

“...[the director of care] is our educator for the facility and provided all infection control and IPAC training to all staff starting with each staff the first week of March. So, all that training was conducted...on a one-on-one basis with all of the staff.”⁴²⁷

“...IPAC training to all the staff starting...the first week of March...”⁴²⁸

On the importance of effective communications, Boreland stated:

“Communication, that is very key. I would say that’s the most important thing with our success because the communication I had with families was constant and consistent. I didn’t hide anything. I didn’t sugarcoat anything. If I had issues, I let them know.

...I made sure that I had at least weekly teleconferences with them to keep them abreast of what was going on.”⁴²⁹



Managers ran and hid during the pandemic and were never seen.

–ONA member, survey response

After reviewing the Ministry policy permitting families and essential visitors, Boreland had concerns that the policy did not require proof of a negative test prior to visiting the home. So Boreland reached out to families prior to tightening the rules:

“So, I got on the phone again with the families...and if anyone wanted to come in for a visit...we would work with them to get a COVID test done for them.”⁴³⁰

On staff cohorting:

“Another thing we did early was...cohorting of the staff. That was a key area, making sure that you have dedicated staff on each area, on each unit, and that they’re not crossing multiple units.”⁴³¹

On isolation pay for staff who tested positive or who needed to be isolated at home:

“...it just made sense for us to just pay people when we put them off because I’m the one that’s putting them off, so I should be paying them... So, we paid everyone that we put in quarantine. And back in March, I had a lot of people off, but it was the safe thing to do, and I don’t regret anything.”⁴³²

On checking residents for symptoms:

“Temperature checks were introduced very early. Back in March, we introduced that, and we did temperature checks for each resident three times a day, and we still have that in place to this day. I believe the Ministry standards are still twice a day, but we never rolled it back.”⁴³³

On making it easier for staff to buy their groceries:

“And in the onset of the pandemic, I also offered all staff that they could buy any product or any food from Mariann Home. So, they could place their food orders with us from Sysco or Gordon Food.

And that was an effort just to avoid staff making unnecessary trips outside of work. So that’s why we arranged that grocery-and-product-buying program for them.”⁴³⁴

But perhaps the most important lesson from Mariann Home was the quality of its leadership. While other long-term care providers were fighting ONA and other unions tooth-and-nail in court and arbitration proceedings, Mariann Home’s leadership was proactively, voluntarily implementing the same measures that were the subject of legal proceedings for other nursing homes.

Organizational experts talk about the importance of tone at the top.

Tone at the top can be defined as:

“...the ethical atmosphere that is created in the workplace by the organization’s leadership. Whatever tone management sets will have a trickle-down effect on employees of the company. If the tone set by managers upholds ethics and integrity, employees will be more inclined to uphold those same values.”⁴³⁵

Boreland and his leadership team at Mariann House exemplified the right kind of tone at the top.

A good example occurred early in the pandemic, as Mariann House was beginning to restrict outside visitors. Boreland stated:

“...we actually closed our facility early. I closed down to – and you had to sign in to come in back on February the 28th. When I closed the doors, I actually moved my office to the screening station, and I did screening for about a week...that is what set the tone in our facility, in my opinion, because the staff saw how serious this was as well as all the visitors.”⁴³⁶

There will be many lessons from COVID-19. Leadership, as embodied by the managers of Mariann Home, may be among the most important.

That the better outcomes at Mariann Home depended on an exceptional leadership team charting a unique course of action – one that sharply differed from the actions and inactions of most other long-term care facilities – is a sign that the problems in long-term care are systemic. If they were not systemic, then most nursing homes would have followed Mariann Home’s example, and we would not need to highlight this exemplary outlier.

Fatal Choices and the Anguish of COVID-19

The words and experiences of registered nurses form the backbone of this report. They offer poignant insights into the magnitude of the anguish and suffering that COVID-19 has caused residents and health care workers in long-term care, and to their families and communities.

In the SARS Commission final report, Justice Archie Campbell wrote:

“SARS taught us lessons that can help us redeem our failures. If we do not learn the lessons to be taken from SARS, however, and if we do not make present governments fix the problems that remain, we will pay a terrible price in the face of future outbreaks of virulent disease.”

Ontario failed to learn from SARS. It failed to redeem the failures of the 2003 outbreak. We are now paying the terrible price Justice Campbell feared we would pay.

It is thanks to the courage, dedication, leadership and commitment of registered nurses and other health care workers that the toll in long-term care is not worse than it already is.

How could this occur in a province as rich as Ontario, with some of the best health care facilities in the country, with world-renowned medical schools, and with the experience of SARS under its belt?

A few nursing homes, like Mariann Home, made thoughtful, well-considered choices that made a difference and saved lives.

In contrast, leaders of Ontario’s public health system, and of too many nursing homes, made bad choices before COVID-19 struck – leaving Ontario and far too many long-term care facilities unprepared for a pandemic.

They continued to make bad choices once COVID-19 hit: Ontario, among other things, by downgrading protections; too many long-term care operators, by refusing to implement required protective measures unless compelled to do so by public health directives, arbitrators and judges.

But that is not the half of it.

It is one thing to make a bad decision, learn from it, and change course. It is quite another to make a bad decision and stubbornly stay the course, despite both growing evidence that the choice was the wrong one, and the wide availability of examples pointing to a better way forward.

Residents, registered nurses, other health care workers and their families and communities continue to suffer the consequences of this continuum of bad decision-making.

History will not be kind if we allow the trauma and heartache of COVID-19 to have been in vain and to fade unredeemed into a distant memory.

We owe it to future generations to do nothing less.

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