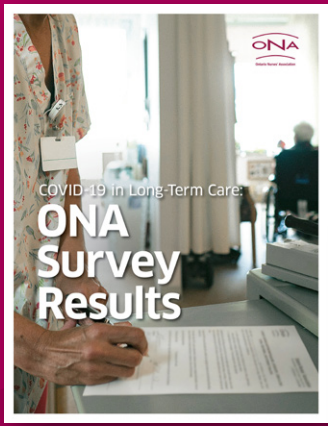
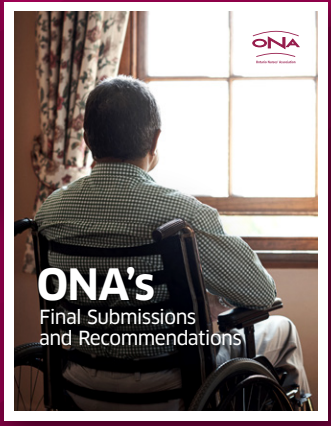
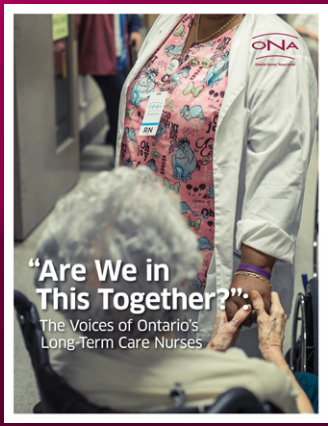
Ontario Nurses' Association

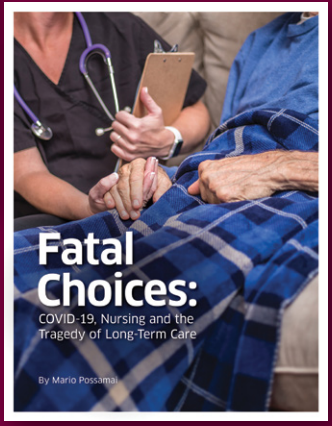
Executive Summaries of Key ONA Reports

Provided to the Long-Term Care COVID-19 Commission









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A Message from ONA President Vicki McKenna, RN

This past year has been nothing short of devastating, particularly for the residents of Ontario's long-term care homes and their families. When COVID-19 reached Ontario in early 2020, it left a path of irreparable damage across our province and in many health-care facilities.

In the early days of 2020, the Ontario Nurses' Association (ONA) was concerned about this new virus and quickly contacted Minister of Health Christine Elliott and Minister of Long-Term Care Merrilee Fullerton. ONA advised the Ministers that the threat was serious and asked about the government's plans to manage and contain it. The government had a simple response to ONA's many valid concerns: We are aware of the situation. Period.

Fast forward to today.

More than 3,700 residents in long-term care have died due to COVID-19. Hundreds of ONA members became ill and we lost one of our very own long-term care RN members to COVID-19.

What happened in long-term care was (and is) tragic and certainly preventable.

As a union that is firmly grounded in advocacy for our members, and for patients, residents and clients, ONA set out to examine the circumstances surrounding the abject failures in the long-term care system.

We heard first-hand from our members who have recounted horrific and heartbreaking stories; their experiences unveiling deplorable conditions and situations.

We took our findings and listened to our members' voices and produced submissions, and multiple reports for the Long-Term Care COVID-19 Commission. ONA's intricately detailed submissions and reports thoroughly examine COVID-19 in the long-term care sector. In addition, a report, commissioned by ONA and authored by SARS expert Mario Possamai, analyzes the circumstances and decisions that led to the state of Ontario's long-term care system.

Most importantly, in ONA's submission to the Commission, we provided sound recommendations that – we hope – will lead to positive concrete changes that long-term care so desperately needs for the health and safety of our members and their residents. After decades of advocating for change, through countless inquiries, commissions and hearings, ONA truly remains optimistic that this terrible situation will not happen again.

I want to express my heartfelt admiration and gratitude to the dedicated nurses and health-care professionals working in long-term care, ONA's leaders and staff. Your commitment to your residents is truly inspiring and I am humbled by your endless courage and strength.

Regards,

Vicki McKenna, RN
President, Ontario Nurses' Association

Ontario's Long-Term Care COVID-19 Commission:

Overview

"This pandemic has only brought forth to the public the issues and concerns that staff who have been working for years in long-term care have been trying to get all stakeholders to pay attention to … and serves only as a wake-up call. Everyone has heard the issues but haven't really listened to make positive change for residents. The issues are not new, they have been long-standing for years and personally, I am angered that this is what has had to happen to make people pay attention. My concern and hope is that there will be change sooner than later. The residents deserve so much more."

—Anonymous ONA Member

When the Canadian Armed Forces issued their report about conditions in Ontario's long-term care homes in May 2020, the media and the public were shocked. Premier Doug Ford said, "It's impossible to know the extent of the problems plaguing the system until you live, breathe, eat it… until you're there around the clock at nighttime and during the day."[1]

ONA members working in long-term care were not shocked. They *do* live and breathe long-term care. They *are* in the homes around the clock. They knew the system was stretched so thin it could not have withstood the smallest of storms. They had tried to warn their managers that COVID-19 would be a crisis, just as the Ontario Nurses' Association (ONA) had tried to warn the government. Warnings that had been given for years, dating back to ONA's involvement in the SARS Commission and multiple inquiries and studies into long-term care, but which were sadly ignored.

On May 19, 2020, the government announced that it was appointing an independent commission to investigate the impact of COVID-19 in long-term care. This development was welcomed by ONA. The Long-Term Care COVID-19 Commission (Commission) was officially established on July 29, 2020 under Section 78 of the *Health Protection and Promotion Act*, which authorizes investigations with respect to the causes of disease and mortality. The Commission's mandate is to investigate and provide a report of findings and recommendations respecting four main areas:

1. State of long-term care prior to COVID-19: how the pre-COVID-19 state of the long-term care homes system contributed to the COVID-19 virus spread within long-term care homes and how residents, staff, volunteers, visitors, family members and others were impacted.
2. Response to COVID-19 by nursing homes and government: the adequacy of measures taken by parties, including the province, long-term care homes and other parties, to prevent, isolate and contain the spread of COVID-19, including the adequacy of existing laws, policies, practices and specifications on infection prevention and control (IPAC) of infectious diseases in long-term care homes.
3. Evaluating realities of the long-term care system: the impact of existing physical infrastructure, staffing approaches, labour relations, clinical oversight and other features of the long-term care system on the spread of COVID-19.
4. Recommendations for changes: in considering the current government initiatives and reforms in the long-term care homes system, any further areas that should be the subject matter of future action by government to help prevent the future spread of disease in long-term care homes.

1 https://www.cbc.ca/news/canada/toronto/military-long-term-care-home-report-covid-ontario-1.5585844

In addition, the Commission was given the authority to consider any other relevant areas needed to investigate the cause of the spread of COVID-19 within long-term care homes and consider any further areas that should be the subject of future action.

On July 29, 2020, the government released the Commission's Terms of Reference[2] and announced the three Commissioners:

- Associate Chief Justice Frank N. Marrocco (Chair) – retired Judge from the Superior Court of Justice.
- Angela Coke – former Senior Executive of the Ontario Public Service.
- Dr. Jack Kitts – retired President and CEO of The Ottawa Hospital.

The Commission is unique. Normally, commissions and inquiries conduct a retrospective review after an event has happened. In this case, the Commission began its work while the COVID-19 pandemic was still underway, and will release a final report on April 30, 2021, before the pandemic ends. The Commission had only nine months to investigate and report back. The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, in comparison, was conducted over a two-year period.

The Commission has conducted all of its work over Zoom video conferences. At the time of writing, the Commission has held approximately 150 video conferences with politicians, government officials, long-term care providers, unions (including ONA), physicians, residents, family members, long-term care staff, and other experts and stakeholders.

The Commission has released two sets of interim recommendations. The first set was issued on October 23, 2020,[3] and are grouped around the themes of staffing, strengthening health-care sector relationships and collaboration, and improving infection prevention and control measures.

Some noteworthy recommendations include:

- Recruitment efforts to address an appropriate skill mix to meet the increasing acuity and complexity of residents.
- More full-time positions.
- A minimum daily average of four hours of direct care per resident, with increases to permanent funding to support more nurses and support staff.
- A dedicated IPAC lead for every home.
- Timely, focused inspections by the Ministry of Long-Term Care (MLTC) and local public health focused on ensuring IPAC measures are properly implemented.
- The prioritization of testing and the quick turn-around of test results for residents and staff in long-term care.

The second set of interim recommendations[4] was released on December 4, 2020 and is grouped around the themes of effective leadership and accountability, performance indicators and inspections. Some noteworthy recommendations include:

- A clear lead for quality of care among the leadership of each home. The Commission recognized that effective leadership makes a significant difference in how long-term care facilities performed.
- Metrics such as resident and family satisfaction, staff engagement, staffing levels and supply of personal protective equipment (PPE) be included in the performance reports for each home and publicly posted.
- Reintroduce comprehensive resident quality inspections (RQIs) annually for each home with appropriate funding to hire and train new inspectors to implement the annual RQIs.
- A centralized system of sharing reports from the Ministry of Labour, Training and Skills Development (MLTSD), public health and the MLTC, with cross-training of inspectors and inspection teams to address specific cross-cutting issues.

2 The full July 29 terms of reference can be found here: http://www.ltccommission-commissionsld.ca/li/pdf/Terms_of_Reference.pdf
The terms of reference were amended in October to include enhanced confidentiality protections. The updated terms of reference can be found here: http://www.ltccommission-commissionsld.ca/li/pdf/TOR_LTC_COVID_Commission_updated-October_2020.pdf
3 The full recommendations can be found here: http://www.ltccommission-commissionsld.ca/ir/pdf/20201023_First_Interim_Letter_English.pdf
4 http://www.ltccommission-commissionsld.ca/ir/pdf/20201203_2nd_Interim_Letter-E.pdf

On December 9, 2020, the Commission wrote to Minister Fullerton asking for an extension of the deadline for its final report to December 31, 2021, citing "significant delays" in obtaining the information it had requested from government. The Commission also noted that COVID-19 was continuing to impact long-term care during the second wave, leading to new information that would inform the Commission's findings and final report. Despite this very reasonable request, on December 23, 2020, Minister Fullerton denied the extension.

Throughout February 2021, the Commission continued to hold meetings and collect evidence. The Commission met with the Minister of Health, the Minister of Long-Term Care, and the Chief Medical Officer of Health and received thousands of pages of documents from the government to review. Submissions and reports from stakeholders, including ONA, were also provided. In addition, ONA met with the Commission twice.

ONA's Participation at the Long-Term Care COVID-19 Commission

ONA formed a team of in-house legal counsel led by Nicole Butt, legal counsel and Manager of Litigation, who had previously represented ONA before the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System; Marcia Barry, senior legal counsel; and Nicholas Baxter, counsel on the Litigation Team. Collectively, they have more than 25 years of legal experience working with ONA and its members on a wide range of legal matters. The team engaged in strong advocacy throughout the Commission to ensure that the voices of our members were front and centre. The legal team's skillful representation was reflected throughout their work. They interviewed hundreds of RNs, systematically collected their testimonials to guide the Commission, and drafted legal submissions and recommendations built on the clinical experience of nurses to develop a pathway forward for change.

The legal team was supported by a dedicated task force subspecializing in a number of areas, including health and safety, professional practice, member mobilization, and communications, as well as ONA's long-term care lead and staff economist. We also commissioned Mario Possamai, senior advisor to the SARS Commission, to prepare a report.

We immediately wrote to the Commission, offering our assistance and advising the Commission of our expertise and long history of advocacy in the long-term care sector.

To ensure that ONA's response was informed by the experiences and voices of ONA members, we distributed a survey to ONA's long-term care members and any members who were redeployed from other sectors during the first wave. More than 1,000 members responded to the survey, providing us with invaluable information and data.

Some comments ONA members made include:

A lot is expected of RNs. We are underpaid and under-valued by society and the government. We are at the bedside in every setting 24/7 and the responsibilities we carry in long-term care specifically are not understood by most, even by our peers in acute care.

I had no power and all of the accountability.

We need action. We need managers to take responsibility and to CARE. The elderly are a forgotten part of society. They need respect. They need to be protected. The basic care staff need increased wages and more education and they NEED to be regulated….Education. Communication. Respect. Increase in basic wages. And more sick time. We get sick. We need paid time off. We work so hard. Why isn't this recognized and respected? Give us more sick time.

MORE STAFF!!!!!!! We need staff-to-patient ratios because "FOR PROFIT" homes will NOT change any other way – they are in business to make money and they do so directly on the backs of their employees… Daycare staff have ratios of staff to infants and toddlers – why do nursing homes not have ratios of cognitively and physically impaired adults?

We also conducted interviews with members working in the hardest-hit homes. These interviews continued throughout the fall of 2020 and into the new year, and included members working in homes that went into outbreak in the second wave.

ONA first met with the Commission for two hours on October 13, 2020. In attendance for ONA were Vicki McKenna, President; Cathryn Hoy, First Vice-President; Bev Mathers, CEO; Pat Carr, Manager, Long-Term Care; Nicole Butt, Manager, Litigation; Marcia Barry, Senior Legal Counsel; and Nicholas Baxter, Legal Counsel. ONA was invited back for a second meeting the following week on October 20. Transcripts of ONA's presentation are available on the Commission website.

We began our presentation with a 10-minute video of ONA members describing their experiences working in long-term care homes during the first wave. The video was

powerful and had a visible impact on the Commissioners who were clearly moved by the stories and emotion displayed by our members. As one nurse said in the video, "The majority of long-term care employees love what we do, love working with our geriatric population. And the public needs to know that. We care."

Following the video, we provided an overview of a "typical" first-wave outbreak, outlining the common failures in so many homes. We contrasted this against stories from homes that had done things well to show that the devastation was not inevitable.

For the balance of the presentation, we discussed in detail the following key issues raised by our members:

- **Staffing, workload, retention and funding**
  - The general staffing crisis that existed prior to COVID-19.
  - Wholly inadequate staffing during COVID-19 that often got worse.
- **Government action**
  - Failure to follow the precautionary principle.
  - Problems with government directives.
- **Issues within the homes**
  - Leadership failures within the homes.
  - IPAC failures, including failure to train, and failure to isolate and cohort residents.
- **Enforcement**
  - Failure of the MLTSD and the MLTC to conduct thorough, independent investigations and failure to issue any orders to address the safety of our members.
  - Lack of effective enforcement mechanisms that led ONA to go to court to seek an injunction to enforce compliance with government directives.
- **Mental Health**
  - The impact the pandemic was having on the mental health of ONA members and the failure of homes or government to ensure adequate supports were in place.

At the request of the Commission, we focused our initial recommendations on short-term immediate actions. Our presentation can be found here and our interim recommendations can be found here.

ONA was pleased to see the Commission's first set of interim recommendations, which were released on October 23, 2020. To amplify the Commission's interim recommendation to increase staffing in order to achieve a minimum daily average of four hours of direct care

per resident per day, ONA held a virtual day of action on December 2, 2020 to protect long-term care. ONA members and the public contacted the Premier, Ministers of Health and Long-Term Care, and MPPs by phone and email. Members also participated in a social media campaign on Facebook, Instagram and Twitter. A focus of the action was the failure of the government to commit any funding in the November budget to its promise to implement the Commission's recommendations.

ONA legal counsel advocated for a process for the Commissioners to hear directly from ONA members. As a result of our advocacy and that of other unions, the Commission set up several ways to hear from front-line staff members in a manner that would protect their confidentiality. To do so, the Commission published revised terms of reference with enhanced confidentiality provisions on October 20, 2020.

Beginning in January 2021, the Commission heard from ONA members through three processes:

a. Confidential one-on-one interviews between members and Commission counsel. These meetings were approximately one hour and were transcribed. Transcripts were provided to the Commissioners, who would read them but keep the information confidential.

b. Group panel presentations with the Commissioners. Transcripts of the panel interviews are available to the public and can be found here: http://www.ltccommission-commissionsld.ca/transcripts/index.html. In order to protect confidentiality, each participant was given a number, and no names are used in the transcripts.

c. Confidential written statements.

Twenty members agreed to do one-on-one interviews, 10 members agreed to participate in the panel interviews, and eight members provided confidential written statements to the Commission.

Some of the comments the Commissioners heard from ONA members during the panel meetings include:

I'm not talking about this pandemic or just these last few months. I'm talking for decades, the constant underfunding of the long-term care sector. This is nothing that the government hasn't been aware of for decades. They just allowed it to be swept under the rug because they didn't want to waste the money before this. It's just – it's disgusting. That's all it is. There are no other words for it other than total disgust. I think the government needs to abolish every for-profit nursing home. They have to establish RN-to-resident ratios, RPN-to-resident ratios, PSW-to-resident ratios. They have to bring in more cleaning services. You have to look at this as an entire – as a whole. You can't just look at it at a micro-level.

I think the government dropped the ball. We knew decades ago when SARS hit that all of this was possible, but 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 other end result than what we have now because they didn't learn their lessons.

But my thing is, we need staff. Staffing, staffing, staffing, staffing, because when they announced that you cannot work in two places, we lost a lot of staff, from PSWs to housekeeping to RPNs to RNs, we lost a lot of staff because most of them chose the municipal homes that pay more.

Long-term care needs help. We are struggling. We are emotionally, physically, we are overwhelmed, overworked and this COVID has taught me so, so much. Our system was broken, but it's really worse now.

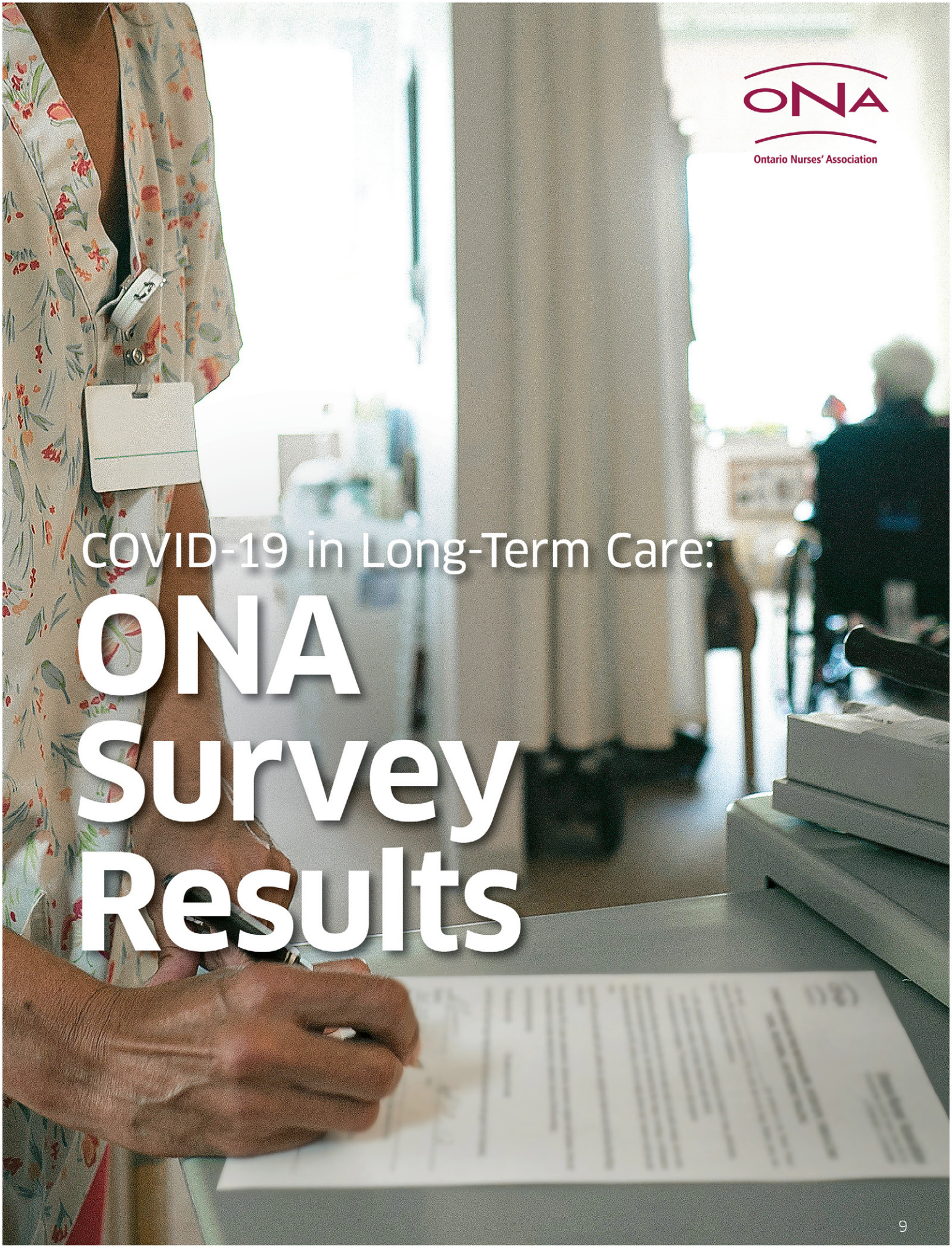
As the second wave deepened, ONA continued to battle with many homes to enforce the terms of Arbitrator John Stout's May 2020 award from the participating homes arbitration. On December 22, 2020, we wrote to the Commission to outline these ongoing issues. We also outlined the latest of the growing scientific evidence that SARS-CoV-2 is an airborne virus, necessitating the need for airborne precautions. We asked for a further interim recommendation that would require, at a minimum, that all health-care workers use NIOSH-approved fit-tested N95 respirators when providing care or when within six feet of suspected, presumed or confirmed COVID-19 residents, consistent with the evolving science around aerosol transmission.

We followed up with a second letter on February 12, 2021 in which we outlined further scientific evidence of airborne transmission and highlighted how Public Health Ontario had mischaracterized this evidence. We again called for application of the precautionary principle and sufficient protection for workers in long-term care.

As we moved into the new year, ONA concentrated on completing our final reports and submissions. ONA provided the Commission with a final report on the long-term care survey, as well as our submissions and recommendations, all of which can be found here. A detailed overview of the survey results and our submissions and recommendations can be found in this document.

We also provided the Commission with two reports. The first is a report ONA commissioned by Mario Possamai, senior advisor to the SARS commission entitled, *Fatal Choices: COVID-19, Nursing and the Tragedy of Long-Term Care.* The second report, *"Are We in This Together?": The Voices of Ontario's Long-Term Care Nurses,* focuses on nursing issues in long-term care and is written by ONA Nursing Researcher/Nursing Health Policy Officer Tanya Beattie and masters of nursing student Christina Pullano. Overviews of both reports can also be found in this document.

ONA's work on the Commission could not have happened without the tremendous efforts of ONA members working in long-term care. Despite the trauma and exhaustion they endured caring for their residents, they stepped forward to bravely share their experiences and insights into the problems and solutions for the long-term care sector. Throughout the pandemic, ONA members in long-term care have done what they do best: they have bravely and tirelessly advocated for their residents. We are honoured to work with you to bring your stories, insights and recommendations to the forefront.



Ontario Nurses' Association

COVID-19 in Long-Term Care:

ONA Survey Results

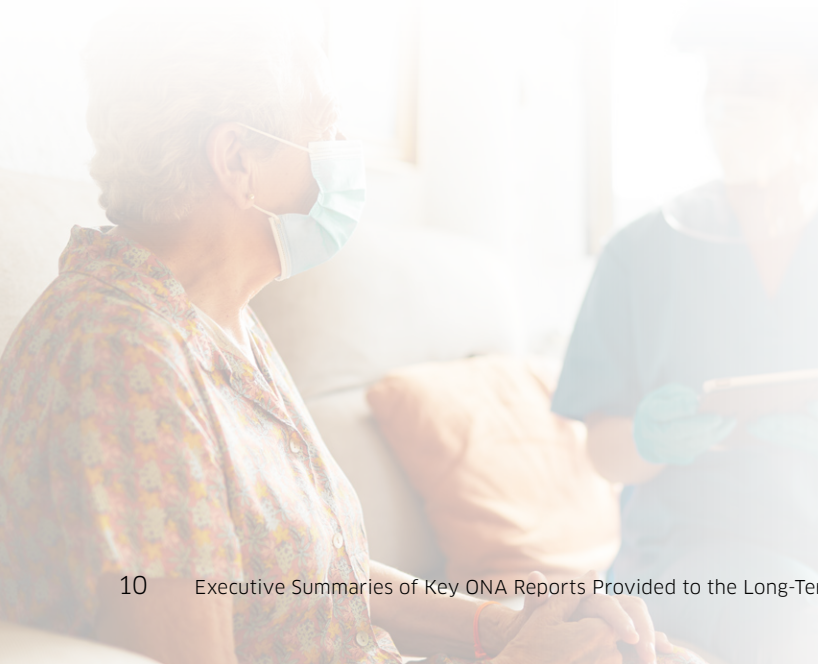
Executive Summary:

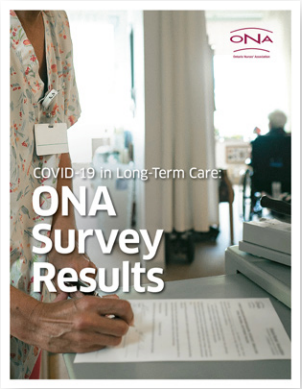
COVID-19 in Long-Term Care: ONA Survey Results

From September 12 to October 4, 2020, ONA conducted a survey of members working in long-term care homes about their experiences during the COVID-19 pandemic. The Ontario Nurses' Association (ONA) sent the survey to approximately 3,300 ONA members: 3,000 who regularly work in long-term care, and 300 who were redeployed to homes experiencing outbreaks. Of those, 1,185 ONA members answered at least part of the survey, and 766 members completed the survey.

The survey focused on four main themes: personal protective equipment (PPE), workload, leadership, and personal impact, which included the health and financial impact of the pandemic.

The responses reveal significant trends around the four themes. Homes with no outbreak performed better in all aspects than those with an outbreak. The data is even more telling when homes that were able to contain an outbreak are compared to those that could not: homes that had contained outbreaks had a better supply of PPE, imposed less restrictions on its use, had better staffing levels, had leaders who were proactive in preparing the home and the staff, and acted swiftly to isolate and cohort residents in order to contain the spread.





The full long-term care survey results can be found here.

Another stark difference was the performance of homes in the not-for-profit sector compared to the for-profit sector. It is well-documented that the not-for-profit sector experienced significantly fewer outbreaks, fewer cases, and fewer resident deaths from COVID-19. We believe our survey sheds some light on why: on nearly every question we asked, the not-for-profit sector performed better.

A final issue to note is the disproportionate impact the pandemic has had on racialized members. Members who identified as racialized are more likely to work in the for-profit sector, and more likely to work multiple jobs. They are over-represented in the homes that experienced outbreaks, and they were more likely to contract COVID-19 themselves.

PPE

The survey asked a range of questions about the ability of members to access proper PPE. Members were asked to indicate any supply issues and any restrictions on use, such as requiring, reusing or permission to access PPE. Members were also asked whether limitations were imposed, such as wearing the same mask when treating healthy and sick residents, and if they had been discouraged from using PPE.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For-Profit
Count	766	436	434	204	174	415	585
PPE	%	%	%	%	%	%	%
Experienced supply issues with N95s	41	30	49	37	65	36	44
Experienced restrictions on use of N95s	77	70	81	76	88	71	79
Told to wear same mask with healthy and sick residents	35	26	38	31	50	24	42
Discouraged from using PPE	20	16	24	20	31	16	22

The key PPE findings were:

- 41 per cent of members experienced supply issues with N95 respirators.
- 70 per cent of members working in homes without outbreaks said they experienced no supply issues with N95s, while only 51 per cent of members in homes with outbreaks said the same.
- Of those outbreak homes, 63 per cent of members working in contained outbreaks reported no N95 supply issues, while only 35 per cent of those working in homes with uncontained outbreaks said the same. Outbreaks, and especially uncontained outbreaks of more than five residents, were associated with higher rates of supply issues with N95 masks.
- This same pattern emerged for other types of PPE, with more supply issues linked to outbreaks, and particularly larger outbreaks of more than five residents.

Workload

The survey data confirms that staffing issues were a serious and widespread problem during the pandemic. Half of all members said the staffing levels in their homes decreased during the pandemic. Nearly one-third of all members indicated that both RNs and RPNs were short-staffed often, defined as several times a week. Two-thirds of members said PSWs often worked short-staffed.

Short-staffing and usage of agency nurses were reported to be worse in homes that had outbreaks, and especially uncontained outbreaks of more than five residents. Forty per cent of members working in outbreak homes indicated RNs were often short-staffed, and this increased to 45 per cent for outbreak homes with more than five resident cases. On the other hand, PSWs were consistently short-staffed whether or not there was an outbreak, or regardless of the size of the outbreak.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For-Profit
Count	766	436	434	204	174	415	585
WORKLOAD	%	%	%	%	%	%	%
Staffing decreased during pandemic	50	48	53	50	59	44	54
Often work short-staffed for RNs	32	26	40	37	45	32	33
Often work short-staffed for PSWs	67	70	66	68	65	63	70
Often used agency RNs during outbreak	13	11	17	12	26	10	16
Often used agency PSWs during outbreak	28	23	36	27	48	16	37

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For-Profit
Count*	766	436	434	204	174	415	585
MANAGEMENT	%	%	%	%	%	%	%
Delay in isolating residents**	13	3	24	13	40	11	15
Delay in grouping residents**	11	4	18	7	33	8	13
Delay in grouping staff*	14	4	24	15	35	11	15
Cleaning was inadequate	23	18	25	20	30	14	30
Not satisfied with leadership	31	26	32	24	42	25	34

* There were slight variations in the total response count for each question as respondents were allowed to skip questions.
** Includes waiting until positive test.

Leadership

Management decisions were crucial to how long-term care homes navigated the pandemic. Members were asked about the quality of key decision-making to contain the spread of COVID-19. In homes that experienced outbreaks, members were much more likely to indicate there were delays in either isolating residents showing symptoms (moving them to a private room), cohorting them (moving them to a room with other symptomatic residents), or cohorting staff so they were assigned to work with infected or healthy residents.

In homes where outbreaks involved more than five residents, the responses were particularly stark, with 40 per cent of members indicating there was a delay in isolating residents, 33 per cent noting there was a delay in grouping residents, and 35 per cent noting there was a delay in grouping staff.

Members were also asked about the level of cleaning in the home and the general leadership of the administration. Members who worked in homes that experienced outbreaks, and particularly uncontained outbreaks, were more likely to report that the cleaning in the home was insufficient to prevent and contain the spread of the virus, and that the leadership was unsatisfactory.

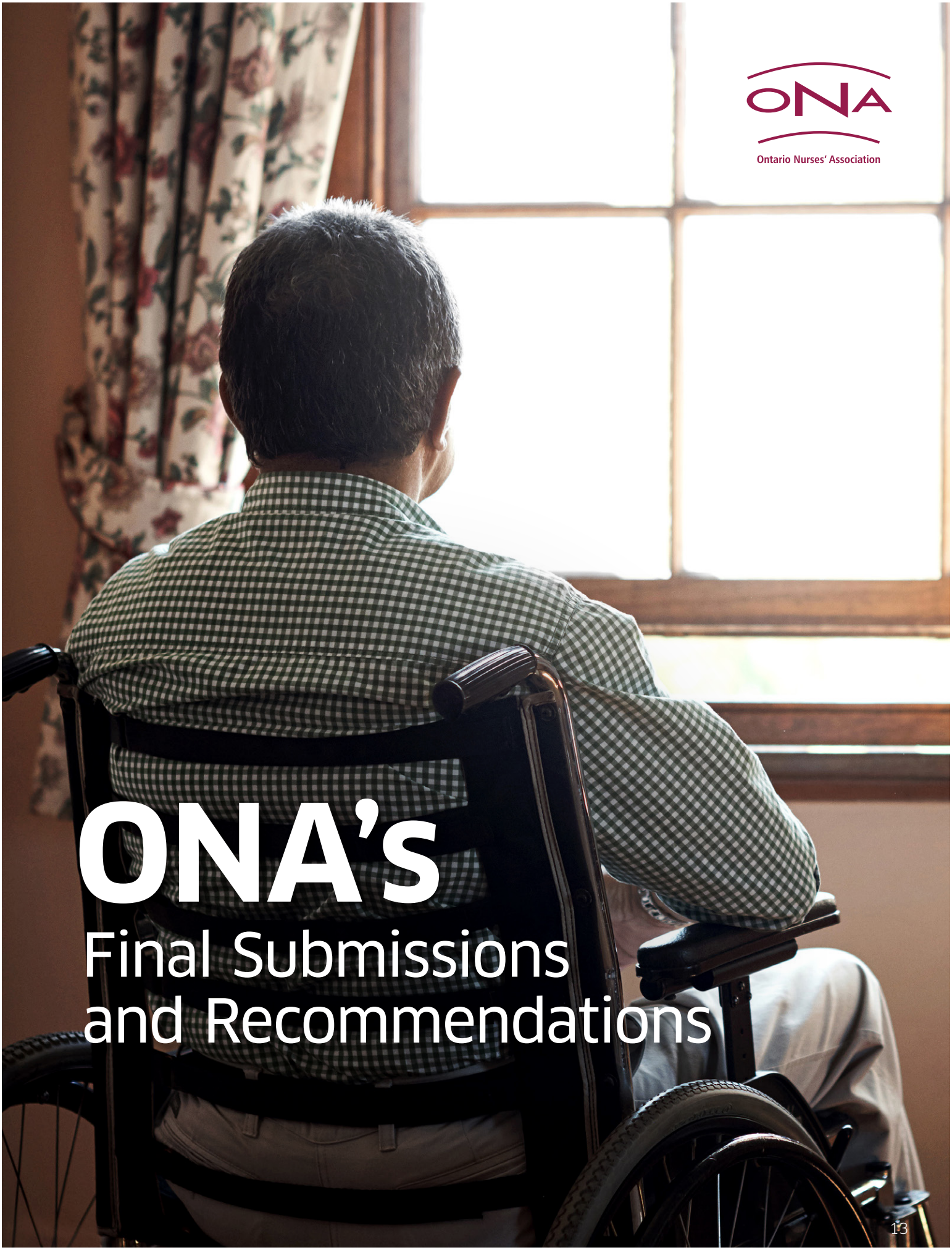
Personal Impact

The survey shows that a large portion of nurses felt that the pandemic impacted their health and finances. Nearly one-third of members indicated they felt inadequately protected because either management took no measures to protect staff from exposure to the virus, or the measures taken were either insufficient or implemented too late. Feelings of inadequate protection were especially reported in homes that had outbreaks, and even more so in homes with uncontained outbreaks. One-fifth of members reported losing hours or income due to being quarantined or isolated.

The full long-term care survey results can be found on ONA's website at: https://www.ona.org/commission.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For-Profit
Count*	766	436	434	204	174	415	585
PERSONAL IMPACT	%	%	%	%	%	%	%
Tested positive	5	1	9	2	16	1	6
Felt inadequately protected**	31	18	44	28	63	22	38
Lost hours or income	21	15	27	21	33	17	25

* There were slight variations in the total response count for each question as respondents were allowed to skip questions.
** Includes no measures, measures considered insufficient and measures considered too late.



ONA

Ontario Nurses' Association

ONA's Final Submissions and Recommendations

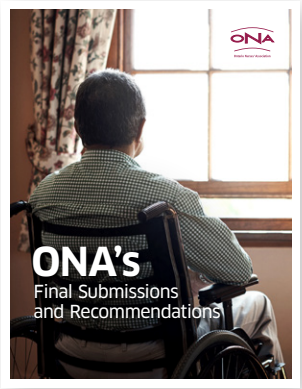
Executive Summary:

ONA's Final Submissions and Recommendations

The Ontario Nurses' Association (ONA) provided written submissions with recommendations to the Commission in early February 2021. These submissions highlight systemic failures in long-term care, public health and emergency management systems, which together created a sector that was completely unprepared to respond to the threat posed by COVID-19.

ONA emphasized that it did not have to be this way. Choices were made in the past, by a series of governments, to not heed warnings that long-term care was severely underfunded and understaffed. RNs, ONA and other stakeholders had sounded the alarm for years, supported by the SARS Commission, reports, coroner's inquests, and a public inquiry, all of which made recommendations that were ignored. These recommendations included increasing staffing, increasing funding, improving working conditions, and improving infection and prevention control (IPAC) practices. The government and long-term care homes ignored the key recommendations from the SARS Commission, most notably the precautionary principle, essential for a novel respiratory illness like COVID-19. The failure to implement these recommendations contributed to the loss of life and illnesses suffered by long-term care residents and staff, including ONA members.

ONA's detailed submissions were accompanied by 105 recommendations to the Commission, aimed at improving systems in order to prevent the horrors of the past year from ever happening again. What follows is a summary of our submissions with some of our key recommendations.



The full report can be found here.

ONA addresses five key themes in our submissions:

1. Staffing and skill mix: systemic understaffing worsened during the pandemic.
2. Funding, including the necessity of increasing the overall budget for long-term care and eliminating for-profit homes.
3. A public health and emergency management system that was unprepared to address a pandemic.
4. Delays by the government and long-term care homes in addressing long-term care in its response to the pandemic.
5. Difficulties and obstacles in implementing and enforcing IPAC and occupational health and safety measures.

In our discussion of each theme, we ensured that the voices of ONA members were front-and-centre, using their stories to bring to life the urgency of the recommendations being provided to the Commission.

> ***Not allowed to use N95, emphasized needing to save money and conserve, emphasized it was not necessary. Made to feel dramatic when expressing concerns.*** —ONA member, survey response

Below, we summarize the key points and recommendations under each theme.

1. Staffing and skill mix: Systemic understaffing worsened during the pandemic.

Long-term care has been understaffed for decades. While the pandemic did not cause the staffing crisis, it did shine a light on just how inadequate staffing levels are, as well as the need to have an appropriate skill-mix of staff to provide care to increasingly acute residents. Long-term care is not a supportive practice environment: there is often only one RN in the building, particularly on evening and night shifts, when there is also no management or physicians on-site. Consultation resources are virtually non-existent.

The COVID-19 pandemic made pre-existing issues that much more difficult. Residents were ill with a new disease about which little was known. Baseline staffing levels, already inadequate prior to COVID-19, decreased further, in some cases, dramatically. This was caused by the single-facility employment rule, staff being required to isolate, or becoming sick. ONA submitted that the government's decision to exempt long-term care homes from the 24/7 RN requirement was short-sighted. It is when residents are most unstable and ill with a novel infectious disease, that they most need RN care.

The survey demonstrates the staffing crisis in the first wave. Forty-three per cent of members reported that their homes did not always have an RN on duty present in the home, with that number increasing to 50 per cent in for-profit homes.

RNs have a critical (and undervalued) role in long-term care. An appropriate skill mix, determined in accordance with the College of Nurses of Ontario (CNO) practice guideline, *RN and RPN Practice: The Client, the Nurse and the Environment,* is required.

Academic research has long documented a positive relationship between higher levels of RN staff with quality of care for residents. A number of recent studies have found that higher staffing and more total nursing hours were related to fewer COVID-19 outbreaks in long-term care facilities, and that nursing homes with COVID-19 outbreaks were twice as likely to have low RN hours.

Key Recommendations made by ONA:

- That the Ministry of Long-Term Care (MLTC) should fund a minimum of 4.1 hours of direct care (worked hours) per resident per day.
- Of those 4.1 hours, 20 per cent should be provided by RNs, 25 per cent by RPNs and 55 per cent by PSWs.
- That there should be one NP for every 120 residents in the home. Research has demonstrated that the presence of NPs increases the quality of care provided to residents.
- Section 8(3) of the *Long-Term Care Homes Act (LTCHA)* should be amended to increase the minimum number of RNs who are required to be on duty and present in the home at all times. The minimum should depend on the size of the home and should also be tied to the number of RNs required to meet 4.1 hours of direct care (worked hours).
- Immediately ensure that long-term care homes are staffed in accordance with the requirements established in the *LTCHA*, its regulations and all obligations under collective agreements. Homes should not be exempted from meeting minimum RN staffing as the failure to staff appropriately puts residents and staff at serious risk.

2. Funding, including the necessity of increasing the overall budget for long-term care and eliminating for-profit homes.

Adequate funding is essential to quality care for residents. ONA addresses three components to funding in our submissions:

a. Overall budget for long-term care must be increased.

b. Problematic funding model, which does not reflect the actual current needs of residents in the home.

c. Eliminating for-profit homes.

Overall funding is simply not adequate given the care needs of residents. It must be increased to permit homes to increase staffing, create more full-time positions, and to provide competitive and equitable salaries and benefits to attract RNs to work in the sector.

The current method for calculating funding, calculating a Case Mix Index (CMI) out of information gathered as part of the Resident Assessment Instrument-Minimum

> *Never worked under circumstances like this. It felt like a terrible nightmare.*
> —ONA member, survey response

Data Set (RAI-MDS) assessments, is inefficient and does not reflect the actual current needs of residents in the home. It is also questionable whether charting for clinical reasons should be integrated with a system of charting for payment.

Municipal and not-for-profit homes receive supplemental funding from municipalities and fundraising initiatives. For-profit homes, in contrast, use some of the base funding in the "other accommodation" envelope as profit. The performance of for-profit homes during the pandemic illustrates that they do not adequately invest in providing care to fragile residents and fail to provide a safe, quality practice environment.

Dr. Nathan Stall published a paper in July 2020 studying first wave outbreaks.[5] He concluded that, while the risk of having an outbreak in long-term care was not directly related to for-profit status, there was evidence that for-profit homes had larger outbreaks and more deaths of residents than non-profit and municipal homes. This was confirmed by the findings of Ontario's Science Table in January, which concluded that for-profit homes had outbreaks "with nearly twice as many residents infected" and "78 per cent more deaths" compared to non-profit homes.

Key Recommendations made by ONA

- The elimination of all "for-profit" long-term care homes within the next five years. In the alternative, newly funded long-term care beds should only be provided to "not-for-profit" homes.
- Funding should be on a flat per-diem basis per resident.
- More full-time positions should be funded with benefits to attract and retain staff.
- Funding to provide RNs in long-term care with compensation parity to hospitals and municipal homes with respect to salary, benefits, pension and working conditions.

3. A public health and emergency management system that was unprepared to address a pandemic.

Ontario's public health and emergency management systems were not prepared to respond to a pandemic. Ontario's public health system was in transition, with funding slashed in 2019 and a plan to drastically reduce the number of public health units. While these plans were not fully implemented when the pandemic hit, there was substantial upheaval within public health, including at Public Health Ontario, leading to a loss of expertise. Compounding this, the provincial government devalued Public Health Ontario's input and failed to consult with them.

In addition, the province's emergency management system was unprepared. The pandemic plan had not been updated since 2013 and did not reflect major changes in the health system, such as the creation of Ontario Health, Ontario health teams and a separate MLTC. The government was left without a roadmap to follow in responding to the pandemic.

Most concerning, Ontario's personal protective equipment (PPE) stockpile was not maintained. The stockpile was created in 2006 following recommendations of the SARS Commission as an emergency supply to protect health-care workers in the event of a future pandemic. This included 55 million N95 respirators. Cabinet was warned that without a stockpile, supplies could become scarce, creating serious problems during a pandemic, especially because Ontario didn't have any capacity for domestic manufacturing. The government did not manage this stockpile, and in fact, destroyed the expired supply of N95s, with such destruction occurring as late as the final quarter of 2019.

5 Nathan M. Stall, Aaron Jones, Kevin A. Brown, Paula A. Rochon, Andrew P. Costa "For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths" CMAJ 2020. doi: 10.1503/cmaj.201197; early-released July 22, 2020

Key Recommendations made by ONA

- The Chief Medical Officer of Health (CMOH) should be accountable for provincial pandemic preparedness; must publicly report, on an annual basis, to the Legislature on the state of Ontario's public health emergency preparedness; and make recommendations to address any shortcomings.
- The CMOH should create and maintain a provincial stockpile of PPE and provide an annual report on the status of the stockpile, including numbers of PPE in stock and expiration dates. The stockpile must be maintained at a level that ensures all health-care workers can be protected at an airborne level for a minimum of three months.
- The province should establish and maintain a domestic PPE manufacturing capability.
- In any future epidemic or pandemic, when determining the precautions for health-care workers, a multi-disciplinary advisory panel must be consulted, including experts in infection control, occupational health and safety, engineering, nursing and geriatrics. It should include representatives from the Ministry of Labour, Training and Skills Development (MLTSD) and union representatives.
- All decision-making on precautions must be guided by the precautionary principle where science is uncertain.

4. Delays by the government and long-term care homes in addressing long-term care in its response to the pandemic.

ONA presents a timeline of the pandemic, emphasizing where the government failed to act to protect long-term care residents and staff. The government missed early warning signs that COVID-19 would be a problem in long-term care, prioritizing hospital preparedness. To the extent that long-term care was considered in February and March of 2020, it was to move patients out of hospitals and into long-term care homes in preparation for a hospital surge.

As early as January 2020, ONA raised concerns with the government, alerting them of the need to prepare the entire health-care sector, including long-term care. We raised concerns about PPE supply, pay for self-isolation, and the applicability of the precautionary principle in January. On February 14, 2020, ONA wrote to the Ministry of Health (MOH) and MLTC, asking about PPE and preparedness and requesting that proactive MLTSD inspections be conducted. A few days later, ONA raised concerns with Minister Fullerton about the impact of COVID-19.

Despite these early warnings, it was April 15, 2020, before Ontario released its action plan for long-term care. This was too late: half the residents who lost their lives due to COVID-19 in the first wave died before April 15. When it finally acted, the government's response was chaotic with a flurry of directives, guidelines, and memos, some of which were contradictory and many of which were issued on Friday evenings, leaving weekend staff scrambling to understand and comply.

Compounding this, homes themselves failed to prepare. Evidence from ONA members demonstrates that many homes either failed or were slow to conduct audits of PPE supplies, begin screening staff and visitors, conduct education on outbreak management, PPE use and other IPAC measures, develop contingency staffing plans, implement universal masking, and implement testing and screening programs for residents.

In many cases, ONA's members tried to put measures in place to prevent and contain the spread of COVID-19. They were often stymied by managers who were unwilling to do anything not yet required by the government. According to the survey, 49 per cent of all respondents said that they raised concerns with their managers or with their Joint Health and Safety Committee (JHSC). That number was even higher in homes with outbreaks.

Homes that were successful in controlling outbreaks were more likely to have adequate and accessible supplies of PPE, better staffing levels, prompt isolation of symptomatic residents and cohorting of residents and staff.

These concerns continued into the second wave, which has been even more deadly that the first. ONA's members have advised the Commission that homes remained unprepared and still experience unacceptably low staffing levels during second wave outbreaks. There also continues to be failures to provide access to N95s and other PPE, as well as a failure to cohort residents.

Key Recommendations made by ONA

- Every home must have an RN who is an Infection Control Practitioner trained and certified in IPAC Canada-endorsed courses. The Infection Control Practitioner will have the authority to make effective decisions about IPAC in the workplace and should be trained in occupational health and safety for employees.
- The precautionary principle must be adopted as a guiding principle in Ontario's public health, IPAC and occupational health and safety systems. It must inform every response to a pandemic, including the development, implementation and monitoring of measures, procedures, guidelines, processes and systems to ensure worker health and safety.
- Individual long-term care homes must maintain their own stockpile of PPE, sufficient to provide protection for all staff for a minimum of three months. The stockpiles and maintenance policies of individual homes should be audited as part of annual inspections by the MLTC.
- Immediately amend Directive #5 to be consistent with the precautionary principle so that nurses and other health-care workers use airborne precautions in the facility.
- PPE must be readily accessible to all regulated health professionals and other health-care workers in the home.

5. Difficulties and obstacles in implementing and enforcing infection prevention and control and occupational health and safety measures.

The government failed to implement the precautionary principle – that reasonable steps to reduce risk should not await scientific certainty – throughout its response to the pandemic. This, the primary lesson from SARS, was ignored by the government and the CMOH, who have failed to acknowledge the growing scientific consensus around airborne transmission.

From the beginning of the pandemic, RNs faced challenges in implementing IPAC and occupational health and safety measures. These measures included isolating residents, cohorting residents and staff, and accessing and using appropriate PPE.

Nursing homes failed to isolate and cohort in a timely manner, including during the second wave. ONA members reported that they were told to isolate residents by drawing a curtain between beds in shared rooms. The physical structure of many homes, with ward rooms, shared bathrooms and other design flaws, such as an absence of doors to close between wings or units, and inadequate ventilation, contributed to the spread of the virus.

Alarming shortages of PPE were reported in homes experiencing outbreaks during the first wave. Respondents to the survey indicated the following shortages in homes with outbreaks:

- 49 per cent reported no supply of N95s for a brief time or longer.
- 17.5 per cent reported no supply of gloves for a brief time or longer.
- 35.6 per cent reported no supply of gowns for a brief time or longer.
- 35.3 per cent reported no supply of goggles for a brief time or longer.
- 39.3 per cent reported no supply of face shields for a brief time or longer.
- 28.9 per cent reported no supply of surgical masks for a brief time or longer.

Access to N95 respirators has been a contentious issue. In mid-March 2020, the government released a Technical Brief, which downgraded precautions to droplet/contact instead of airborne. Employers, on the basis of that Technical Brief, began to deny RNs and other health-care workers access to N95s. This continued after Directive #5 was issued. N95s were often locked up and inaccessible. RNs were discouraged from using N95s, directed not to use them, and repeatedly told that N95s were not needed despite poorly ventilated conditions of long-term care homes and prevalence of aerosol generating behaviours and cognitive conditions that prevent residents from adhering to infection control practices.

ONA members reported unsafe working conditions to the MLTSD, but inspections were ineffective: they were conducted by phone in March and April, and inspectors took the position that employers had taken every precaution reasonable in the circumstances if they were compliant with CMOH directives. Similar obstacles occurred when members called the MLTC to report that residents were not being properly isolated and cohorted.

ONA decided to take the extraordinary step of seeking an injunction from the Superior Court of Justice ordering four long-term care homes to comply with Directives #3 and #5, including resident isolation and cohorting, and to provide nurses with access to N95 respirators and other PPE.

Justice Morgan released his decision on April 23, 2020, ordering long-term care homes to provide nurses with access to fitted N95 respirators and other PPE when assessed by a nurse at point of care to be appropriate and required. He also ordered them to implement other controls, including isolating and cohorting residents and staff. He found that "where the lives of nurses and patients are placed at risk, the balance of convenience favours those measures that give primacy to the health and safety of medical personnel and those that they treat."

After this decision was released, ONA and the participating long-term care homes agreed to an expedited arbitration process with Arbitrator John Stout. He issued a decision in early May 2020, incorporating Justice Morgan's decision and setting out comprehensive infection control and health and safety measures.

Since that time, ONA members have repeatedly raised concerns about their employer's failure to comply with the directives and orders of Arbitrator Stout. ONA has had to police nursing homes who continually breach the right of nurses to have access to N95 respirators, still locking them up, and miscommunicating to staff that N95s are not required and that surgical masks are sufficient because COVID-19 is only spread through droplet and contact. ONA has sent numerous letters demanding compliance with Arbitrator Stout's decision and has had to return to Arbitrator Stout to ask for orders.

It is unacceptable that there is not a simple expedited method to enforce public health directives and to resolve concerns about worker health and safety. The current process is unwieldy and time-consuming, given that the directives address matters critical to life and death.

Key Recommendations made by ONA

ONA made numerous recommendations to strengthen enforcement and inspection regimes, and also suggested amendments to the *Occupational Health and Safety Act (OHSA)*, *Health Protection and Promotion Act (HPPA)* and the *LTCHA,* including the following:

- MLTSD inspections must be in-person, on-site. Inspectors must speak to the workers, including the worker who made the call to the MLTSD and must exercise independent decision-making during the inspection process.
- The MLTSD should conduct proactive inspections at the outset of a pandemic to ensure that long-term care homes are prepared, from a health and safety perspective, to respond to a pandemic.
- MLTC annual resident quality inspections (RQIs) must be reinstated with a focus on IPAC practices, pandemic planning and health and safety.
- Strengthen whistle-blower language in the *OHSA*, the *LTCHA* and in the *HPPA* so that nurses who raise public health risks are not subject to reprisal.
- Amend the *OHSA* to enshrine the precautionary principle as an employer duty, to require all employers to prepare and regularly review a pandemic plan, and to provide the JHSC with monthly reports on the supply of PPE.
- Amend the *OHSA* to include a section specific to infectious diseases that would require notification of exposures.

Impact

ONA submissions conclude by highlighting the significant mental health toll that this crisis has had on RNs, RPNs and other health-care workers in long-term care. We recommend that mental health supports must be provided to employees, including counseling for a period of at least two years at no cost. We also recommend that nurses who worked in long-term care homes with an outbreak should be entitled to damages for mental distress/post-traumatic stress disorder.

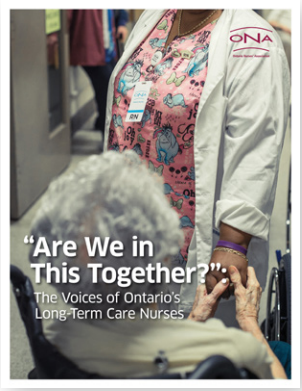
A full copy of ONA's submissions and recommendations can be found on ONA's website at: https://www.ona.org/commission.

"Are We in This Together?":

The Voices of Ontario's Long-Term Care Nurses

Executive Summary:

"Are We in This Together?": The Voices of Ontario's Long-Term Care Nurses



The full report can be found here.

The Ontario Nurses' Association (ONA) prepared this report to highlight the unique role RNs play in long-term care to assist the Commission in understanding the need for more RNs in the skill mix. The report was prepared by Tanya Beattie, ONA's Nursing Researcher and Health Policy Officer, and Christina Pullano, a master's student in nursing.

The report presents a pre-pandemic background on staffing in long-term care, and the impact these historical issues and additional COVID-19 pressures had on the professional and personal experiences of ONA members, from a nursing and quality of care lens.

Background

The proportion of RNs in the long-term care sector has decreased between 2013 and 2018. As of 2018, 58 per cent of long-term care employees were PSWs, and 25 per cent were RNs/RPNs. Of the 25 per cent registered staff, 62.9 per cent were RPNs and 36.5 per cent were RNs. Despite a steady increase in resident acuity and overall care needs, Ontario long-term care homes have failed to make corresponding changes in staffing levels or skill mix.

RNs working in long-term care have great responsibilities, heightened by the fact that they are often working as the sole RN in the building with limited on-call support. RN practice in long-term care entails a high level of critical thinking in order to provide care to residents who may have critical and rapidly changing needs.

The report reviews the role of the RN in long-term care through the College of Nurses of Ontario (CNO) Practice Guideline, *RN and RPN Practice: The Client, the Nurse and the Environment*.

While resident acuity has steadily increased over the years, there has been no corresponding change to staffing levels or skill mix. The report reviews data that substantiates the rising acuity, which leads to more frequent and more types of interventions, such as Peritoneal Dialysis, IV medication administration, and G-tube feedings. The increasing acuity of residents requires more RN staff.

While RPNs assume similar roles to RNs in long-term care settings, their autonomous practice is limited to providing care for residents who are less complex, more predictable with a lower risk of negative outcome(s) in a stable, predictable environment.

The environment in long-term care is one in which nurses work very independently, with few practice supports and consultation resources. On evenings, nights and weekend shifts, there is often only one RN in the home.

> *No screening or COVID testing of residents. So we didn't know who was positive and who was negative.* –ONA member, survey response

Understaffing of RNs places residents' well-being and an RN's ability to meet legal and professional accountabilities in jeopardy. Working conditions and a negative public image of long-term care have contributed to recruitment and retention issues in the sector, worsening the already existing staffing shortages, reducing continuity of care and risk to residents.

During the Pandemic

The further reduction in staffing as a result of COVID-19 caused additional workload on already burdened staff and made it challenging to meet all the needs of residents. Nurses were put in a situation that left them fearful that they could not assess and provide care for residents, follow best practices, supervise and support other team members, comply with infection prevention and control (IPAC) measures (including the requirement to cohort staff), and meet CNO standards.

The report reviews how staffing challenges impacted resident outcomes, reviewing several studies that have demonstrated a correlation between RN staffing levels and resident outcomes during the pandemic.

Inadequate IPAC measures, shortages and limitation of the use of personal protective equipment (PPE) contributed to the devastating impact of COVID-19 in long-term care. Poor leadership also had important implications in preventing the spread of COVID-19. A dedicated, full-time IPAC RN is a crucial strategy to help prevent and control future outbreaks.

Their experiences during the pandemic have put the mental health of many RNs in jeopardy. Even before the pandemic, studies have noted significant occupational stress and high levels of burnout among long-term care staff. Many of the conditions reported by ONA members during the pandemic, such as increasing job demands, decreasing ability to meet professional standards, traumatic experiences, and lack of support, are reported in the literature as negatively impacting the mental health of front-line health-care workers.

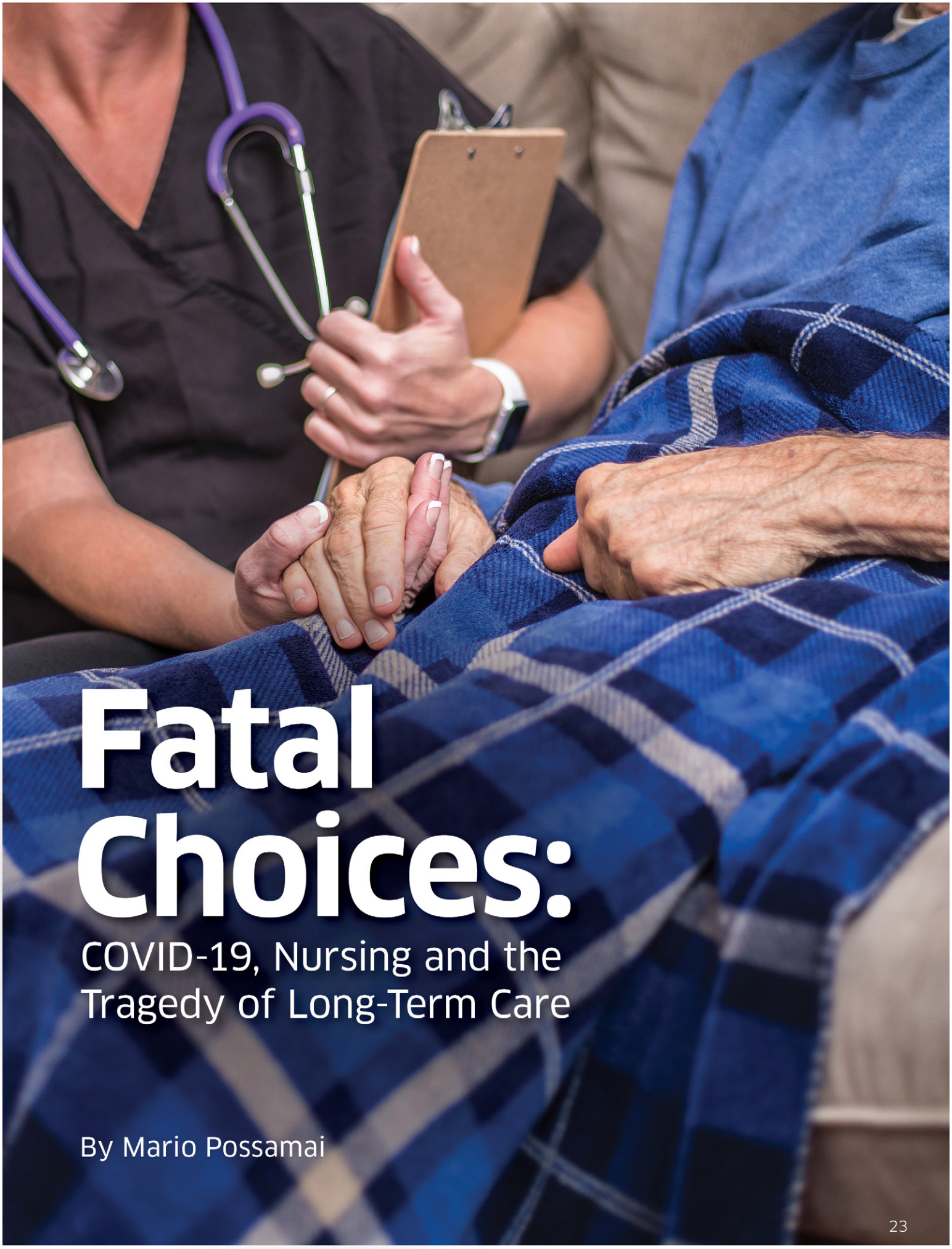
Conclusion

Early research linking improved COVID-19 outbreak response to RN care hours is promising. For RNs, these findings only reiterate what they already know – more RNs mean improved resident care and outcomes.

Decision-makers must recognize that RNs are the clinical experts during the pandemic. RNs understand what needs to be done to protect themselves and their residents, but they must have the necessary resources and support. Creating a supportive, quality practice environment – by ensuring appropriate staffing levels, compliance with IPAC measures including access to PPE, with strong effective leadership in the homes – is critically important.

The time is now to make monumental changes to Ontario's long-term care system to ensure that seniors receive the quality care and quality of life that they deserve.

The full report, *"Are We in This Together?": The Voices of Ontario's Long-Term Care Nurses*, can be found on ONA's website at: https://www.ona.org/commission.



Fatal Choices:

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

By Mario Possamai

Executive Summary:

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

The Ontario Nurses' Association (ONA) retained Mario Possamai as an expert to author a report analyzing the circumstances and decisions that have led to the state of Ontario's long-term care system. As a senior advisor to the SARS Commission, Possamai is uniquely qualified for this work. He worked closely with Justice Campbell on the SARS Commission Report, and developed expertise in issues of worker health and safety during a health crisis.

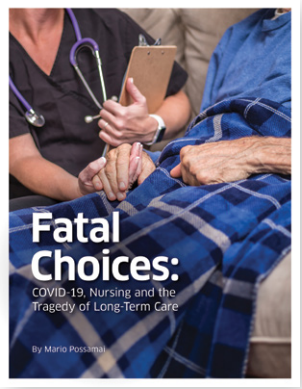
While COVID-19 was on a more dramatic scale in terms of devastation than SARS, Possamai concludes:

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."

The 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."

A central theme of the report is the failure to listen to the clinical judgment of registered nurses, who had invaluable experience often as the most skilled, clinical lead in homes:

- 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.
- 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.



The full report can be found here.

Possamai argues that the devastation in long-term care could have been prevented had the recommendations of SARS and studies in long-term care been implemented and the warnings of RNs heeded.

Possamai's 10-chapter report focuses on the failures of government and nursing homes:

- The failures of the Ontario government to learn from SARS, especially when compared to our "SARS peers" like China, Hong Kong, and others who had much lower infection rates among health-care workers and residents.
- The institutional neglect of long-term care.
- The experiences of RNs during COVID-19, their ongoing fight for personal protective equipment (PPE) and other safety measures, and what RNs see as the core solutions.

The Failures of Government

In chapters two to four of the report, Possamai concludes that the precautionary principle, the cornerstone of the SARS Commission report, was not implemented in the government's decision-making during the COVID-19

pandemic. He reviews several catastrophic decisions by government and officials leading up to the first wave:

- Ontario downgraded PPE precautions for health-care workers to contact/droplet for routine care of COVID-19 residents/patients.
- Ontario did not replenish the N95 stockpile years after it expired.
- Ontario did not act with urgency to prepare for a pandemic for "a future SARS," instead prepared for the flu, and failed to address the PPE shortages.
- The Chief Medical Officer of Health (CMOH) failed to also prepare for a pandemic and act as a public guardian to protect against public health risks like COVID-19.
- Ontario did not create a workplace safety agency like the American National Institute for Occupational Safety and Health (NIOSH) to regulate standards of PPE.

Possamai frames the March 2020 decision to downgrade PPE precautions for health-care workers as being felt most in long-term care given the soaring rate of health-care worker infections. He finds that the Ontario government's decision to downgrade was tied to a political pressure campaign from infection control experts, rather than the precautionary principle for a virus that was little understood and with mounting scientific evidence.

Even as the World Health Organization, Centers for Disease Control and Prevention, and Public Health Canada have recognized aerosol transmission, Ontario has not updated guidance on routine precautions for health-care workers.

Institutional Neglect of Long-Term Care

In chapter five of the report, Possamai reviews historical issues that have contributed to the current condition of long-term care:

- Infection control and health and safety cannot act as two solitudes but must be bridged with both perspectives involved for critical decision-making in long-term care.
- Outdated infrastructure.
- Chronic staffing issues and poor working conditions.
- For-profit homes.

He concludes that successive governments have failed to act on numerous reports in long-term care over the last three decades, resulting in many missed opportunities to protect residents and staff during COVID-19.

The Voice of Registered Nurses and ONA's Fight

In chapters six to nine, Possamai argues that had RNs been listened to, and their clinical knowledge and experience valued, the devastation of COVID-19 could have been avoided or lessened.

RNs were abandoned and at risk – the CMOH's directives were not being implemented and many workplaces made PPE inaccessible. Possamai found that ONA was required to step in to protect their members because the Ministry of Labour, Training and Skills Development (MLTSD) was not exercising its duties to protect health-care workers.

Following ONA's success at court and arbitration to enforce health and safety standards, Possamai found that ONA continued to struggle with enforcement of those decisions. Even into the second wave, employers continued to fight with ONA on the implementation of standard infection control and health and safety measures.

> ***We were yelling into the void that we needed staffing and no one was listening.***
> —ONA member, interview with ONA counsel

RNs know what the solutions are to fix Ontario's COVID-19 response. Employers and governments each have a role in solving the myriad of issues across the long-term care sector.

Conclusion

Possamai says that "hubris," exaggerated overconfidence by medical professionals, triumphed over "humility," which underlies the precautionary principle, the central lesson from SARS:

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.

He highlights Mariann Home, a non-profit, 64-bed facility in Richmond Hill, as an example of successful pandemic containment, but as a stark exception in contrast to most other nursing homes, which is a sign that the problems in long-term care are systemic in nature.

Possamai finds that a few homes like 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 and residents suffered the consequences of this poor decision-making. Possamai concludes this tragedy must not be in vain:

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.

The full report, *Fatal Choices: COVID-19, Nursing and the Tragedy of Long-Term Care*, can be found on ONA's website at: https://www.ona.org/commission.

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

—ONA member, interview with ONA counsel

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 from the non-existent PPE but continuing to work because if I didn't stay, there would be no staff.

—ONA member, survey response

I was redeployed to a home from a hospital. The experience made me very sad and worried me very much. It was honestly devastating to see the conditions that people were living in and working in.

—ONA member, interview with ONA counsel

So the first thing that I'd like to point out is the fact that the military had to expose the conditions frankly speaks to how little … people listen to us in health care. We've been saying it for years and nobody heard it until the military comes in and now people care all of a sudden.

—ONA participant, Commission Group Panel

The residents that I was providing care for could not be isolated and were not capable of wearing protective equipment. I was not provided with proper PPE; gown with no elastic at cuff, no head covering, paper surgical mask, no N95, short disposable gloves that made it impossible to tuck cuffs of gown into.

—ONA member, survey response

Severe lack of communication about the often daily changes to policies and procedures. Staff was often unsure, confused, had no answers. Night shift left out completely.

—ONA member, survey response

I feel I suffer from PTSD after working in the home. I was isolated from my family, my children for weeks. I felt like my colleague and I were thrown to the wolves to fend for ourselves.

—ONA member, survey response

I have worked there for 20 years. Ownership changed three times. Every change came with more cuts, cuts, cuts. More for-profit meant cutting the budget and cutting staff.

—ONA member, interview with ONA counsel

Though I was never in favour of for-profit long-term care, I now firmly believe it should be eliminated as companies continued to pay out dividends while residents and staff died and were not properly supplied or cared for.

—ONA member, survey response

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