



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

October 21, 2020

STAFFING

- 1. Immediately require every licensee to ensure that long-term care Homes are staffed in accordance with the requirements established in the *Long-Term Care Homes Act*, its regulations and all obligations under collective agreements.**

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

- 2. There shall be no layoffs while Bill 195 is in effect, despite changes to the Case Mix Index (CMI) or occupancy.**

Rationale: Despite the seriousness of this pandemic, front line health care jobs in Ontario’s LTC sector continue to be threatened by layoffs. LTC Homes such as Heritage Place, Good Samaritan Nursing Home, IOOF Barrie and Port Perry Place (Allied) have issued layoffs and/or notices of elimination of position. It is essential that there be a moratorium on layoffs, particularly in the LTC sector, given the staffing crisis across the Province. In the context of a pandemic, collective agreement provisions, particularly those around staffing, should be exceeded, not relaxed.

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

Rationale: As recognized in the Gillese Inquiry, wages in the for-profit LTC sector continue to be a barrier for staff retention. The wages do not adequately compensate our members for the current working conditions within the for-profit sector. Temporarily increasing the wages will assist some Homes in retaining staff to satisfy an urgent need in the Second Wave. This has been done already in British Columbia and for personal support workers in Ontario.

- 4. The Ministry of Long-Term Care should immediately increase the funding per Home to ensure there is 4.1 hours of direct care (worked hours) provided by RNs, registered practical nurses, and personal support workers. Of those hours, 20% should be RNs, 25% registered practical nurses, and 55% personal support workers.**

Rationale: The Ministry of Long-Term Care (“MLTC”) must immediately increase the funding to LTC Homes to reflect the urgent care needs of the increasingly aged and high acuity population. The Ontario Long-Term Care Staffing Study Report issued on July 30, 2019 recommended that

LTC Homes should be funded and staffed to ensure that each resident receives a minimum of 4 hours of direct resident care per day. ONA believes that 4.1 hours of direct care relates only to the care provided by RNs, registered practical nurses, and personal support workers.

- 5. During any outbreak, LTC Homes must upstaff RNs, registered practical nurses and personal support workers. The Ministry of Long-Term Care must provide funding so that this can be implemented immediately.**

Rationale: Upstaffing is essential during an outbreak to prevent and contain transmission, and to protect residents and staff. The workload of staff increased exponentially during this pandemic. RNs were required to assess their assigned residents multiple times throughout the day, provide increased care for infected residents, contact families, complete IPAC audits, don and doff personal protective equipment (“PPE”) between residents, and fulfill the responsibilities of coroners and funeral directors in the Homes. During outbreaks, resident acuity levels increased, adding to an already unmanageable workload. LTC Homes must anticipate that staff may become sick, or otherwise be unable to attend work, and must use the staff that are available to upstaff.

- 6. The Ministry of Long-Term Care must provide immediate funding to LTC Homes which the Homes will be required to use to create more full-time positions with benefits to attract and retain staff.**

Rationale: “Full-time” is defined as a regular work schedule of a minimum of 75 hours on a bi-weekly period. According to the Ontario Long-Term Care Staffing Study, only 40% of RN positions in LTC are full-time. It was recognized in the Gillespie Inquiry that one of the factors which contributed to the LTC staffing crisis is the lack of full-time positions with benefits. Full-time positions in LTC are highly sought after as they provide the stability and consistency in hours of work that part-time and casual work do not. Increasing full-time positions would also minimize the need for health care workers to work for multiple health care employers.

- 7. Part-time employees who choose to work at a single LTC Home should be provided with full-time hours. Licensees/operators must not offer hours to agency or full-time employees at overtime until all part-time employees have been offered available hours.**

Rationale: ONA’s survey indicates that hundreds of members have suffered serious financial harm due to being restricted to one workplace. ONA continues to hear stories about LTC Homes not offering full-time or overtime hours to part-time RNs, even when hours are available, and instead utilizing agency staff. The prevalence of precarious work in the LTC sector continues to cause serious recruitment and retention issues that need to be immediately addressed. Using agency workers actually costs Homes more than providing additional hours to existing staff would cost.

INTERDISCIPLINARY TEAMS

It is critical that the RN is supported by not only a team of other RNs but also an interdisciplinary team that includes leadership, physicians, and Infection Control Practitioners.

- 8. During any outbreak the Director of Nursing and Administrator must alternate the times of day they are in the LTC Home to provide leadership and direction at times other than Monday to Friday during the daytime.**

Rationale: During the First Wave, our members in LTC reported that in many cases supervisors were inaccessible to staff or not present in the Home regularly during the peaks of a Home's outbreak. It is always essential that management be available during an emergency, such as the current pandemic, as staff require the support and leadership needed to do their work.

- 9. The role of the medical director needs to be clarified so that it is clear that they are expected to attend the Home in person during an outbreak.**

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

- 10. Every Home must have an RN who is an Infection Control Practitioner who is trained and certified in IPAC Canada-endorsed courses. This education should include IPAC Canada's:**

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

Ideally, the Infection Control Practitioner will be or will agree to be certified in Infection Control (CIC). In the interim, every Home should be provided with an IPAC expert to do an assessment of the Home's preparedness and training to staff.

Rationale: The First Wave demonstrated the critical need to have infection control expertise in LTC Homes. Many Homes did not have a dedicated infection control RN to proactively implement policies and procedures to protect residents and staff.

An RN who is certified in an IPAC Canada endorsed course will have the knowledge to identify when and how Homes implement cohorting and isolation protocols. They will be able to teach appropriate donning and doffing of PPE and ensure that the Home is compliant with fit-testing requirements. We recommend further that the IPAC Practitioner have health and safety training.

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

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

- 12. Immediately cease requiring RNCas to perform the roles of funeral director and coroner during an outbreak. Funeral directors and the coroner can safely attend in LTC Homes wearing personal protective equipment for airborne protection.**

Rationale: RNs were given the responsibility to complete death pronouncement processes for deceased residents. The death pronouncement process was previously completed by coroners or funeral directors who would enter the LTC Home. Upon a resident's death, RNs were required prepare the body, place the body in a bag, and take the body out to the front of the building to be picked up by the funeral home. This responsibility caused a substantial increase in workload for our members and was a significantly traumatic experience for some. Coroners and funeral directors should attend as needed with appropriate safety precautions in place in order to alleviate the burden on RNs.

COMMUNICATION AND RESIDENT CARE

A. Government Communication

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

Rationale: The SARS Commission established the precautionary principle as a fundamental aspect of worker health and safety:

The point is not who is right and who is wrong about airborne transmission. The point is not science, but safety. Scientific knowledge changes constantly. Yesterday's scientific dogma is today's discarded fable. When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.¹

These statements by Justice Campbell apply with equal if not greater force to COVID-19. We are simply repeating the errors of the past by re-engaging in similar debates based on an evolving science that changes rapidly. We need to learn from the lessons of SARS.

The precautionary principle is a health and safety obligation requiring government and employers to take proactive and substantive action to protect health and safety to workers. The precautionary principle has not been appropriately implemented in this pandemic. It requires employers to immediately implement the maximum level of protection through PPE (i.e. N95s) and training.

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

Rationale: Health Care Workers were bombarded with numerous directives, orders, and guidelines which were not always completely consistent, leading to confusion and delays in implementing important measures to protect residents and staff.

¹ Ontario, & Campbell, A.G. (2006). *Spring of Fear: The SARS Commission final report*. Toronto: SARS Commission, Vol. 1, p. 12

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

Rationale: The Government's current practice is to delete the previous versions of directives from the Chief Medical Officer of Health ("CMOH") from the Government website. For those who do not have a copy of the previous directive it would be simply impossible to determine the changes that were made from the previous version, and these changes should be transparent and easy to find

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

Rationale: Employers treat the CMOH directives as the ceiling of infection prevention and control standards, rather than a floor, and have failed to implement additional precautions necessary depending on the particular circumstances. In many LTC Homes, employers have failed to take the necessary, proactive action required to prevent or minimize the extent of infections and outbreaks.

B. Communication in Long-Term Care Homes**17. Administrators/Directors of Nursing/Assistant Directors of Nursing should be communicating with families and substitute decision makers.**

Rationale: In addition to providing direct care and carrying a very heavy workload, RNs are required to speak with residents' families. Our members report that this was difficult work and they often lacked the information many family members were seeking. LTC Homes need to designate a representative who could provide regular updates to families and respond to inquiries.

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

Rationale: Our members who have worked and continue to work in LTC Homes in outbreak are not provided the basic information required to implement infection prevention and control measures. In some Homes during the height of the outbreak, staff were not told which residents had been confirmed positive for COVID-19. In addition, some LTC Homes were demanding that staff come to work while infected with COVID-19. Some employers did not communicate whether the resident was positive, what their ongoing status was, and corresponding measures and procedures that were put in place to prevent the spread of COVID-19 in the Home. This contributed to the spread of infection to residents and health care workers in the LTC sector.

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

Rationale: As above, all infection prevention and control measures require staff to know who is positive with COVID-19.

- 20. Daily huddles on every shift should be held to discuss new or updated policies, procedures and measures. Huddles should also include new and emerging treatment and care protocols particularly for emerging diseases (e.g. COVID-19) and how to provide supportive care. Information should be documented in a binder or on an electronic platform so that it can be shared with staff working on the evening and night shifts.**

Rationale: The ONA survey confirmed that there was a significant lack of communication from the Government and employers about changes to procedures and protocols. Staff's ability to exercise clinical judgement is affected when they do not have the latest information about applicable policies and disease processes. Education on the emerging science on COVID-19, including what was unknown, consideration of the precautionary principle, and how this translated into the delivery of care to suspect, probable, or confirmed COVID-19 residents, was sorely lacking on the frontlines.

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

Rationale: We heard from our members that in many cases residents' advanced medical care directives and DNRs were not relevant in the context of the pandemic. In the context of a novel virus, it is important to know the wishes of the residents regarding their care.

INFECTION PREVENTION AND CONTROL

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

- 22. All staff must receive comprehensive training on the following:**

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

Rationale: ONA's survey of members employed in LTC revealed that many nurses in LTC had not received ongoing training on IPAC and health & safety measures prior to the COVID-19 pandemic. Some had never received this training. Our survey and interviews have also revealed that many nurses are not receiving comprehensive hands-on training that meets their needs. Many nurses have also stated they did not receive any training in the disease process of COVID-19. Proper training must be in-person and hands-on. Reviewing documents, e-learning, or having nurses watch videos on YouTube is not sufficient training.

23. Directives must mandate that:

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

Rationale: In order to keep COVID-19 out of LTC Homes, there needs to be measures to ensure that admissions, readmissions, and residents who leave the grounds are not infected when they return or are isolated so that they are not spreading the infection in the Home.

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

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

- c. Staff and residents should be tested every two weeks in a manner that is least intrusive (e.g. sputum testing instead of Nasal Pharyngeal testing.) Results must be received within 48 hours, therefore Homes must either receive priority testing or new fast testing.**

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

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

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

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

Rationale: Agency workers are as likely to spread the virus as LTC staff. To protect against the spread from facility to facility, they must be treated in the same manner. While it may be true that agency personnel are essential during COVID-19, the staff who are committed to working in these Homes must be considered first for any available work because they know the residents and they are not working elsewhere.

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

Rationale: Lack of clarity in the public health guidance on return to work led to many employers requiring nurses to return to work when they may still have been infectious. It is essential that employees not be required to return to work until it is clear that they pose no risk of infection. In ONA's survey of LTC members, 17.53% of nurses who tested positive for COVID say they were required to return to work while still exhibiting symptoms. 36.99% say they were required to return to work before receiving 2 negative tests, and 22.73% say they were required to return to work before 2 weeks had elapsed since their first positive test. ONA is very concerned that recent public health guidance has reduced the time workers must be off work from 14 days to 10 days.

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

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

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

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

i. Every LTC Home will implement enhanced and terminal cleaning during the period of the pandemic.

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

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

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

B. Measures to Respond to COVID-19 in Long-Term Care Homes

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

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

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

Rationale: There is still no scientific certainty on how the COVID-19 virus is transmitted. In July, 239 scientists sent a letter to the World Health Organization stating their belief that COVID-19 could be transmitted by air. Most recently, the Centers for Disease Control in the United States and Canada’s Chief Medical Officer of Health, Dr. Tam, have recognized that the virus could be airborne. Without an acknowledgement in Directive 5 that the COVID-19 virus might be airborne and at minimum of the scientific uncertainty about the mode of transmission, employers continue to insist that N95s are not necessary outside of an Aerosol Generating Medical Procedures, and employees are provided with misleading information. This is clearly relevant to containing the spread of COVID-19. The current rate of infection for health care workers is extraordinarily high.

27. Every LTC Home must have an adequate supply of PPE, including gloves, gowns, goggles, face shields, surgical masks and NIOSH-approved fit-tested N95 respirators (or equivalent or better protection.) At a minimum, an adequate supply of PPE would be a three-month supply.

Rationale: It became obvious in the First Wave that many LTC Homes did not have an adequate supply of PPE. Some outbreaks lasted more than two months, and a number of Homes have experienced multiple outbreaks. A three-month supply is a minimum to ensure the supply issues seen in the First Wave do not reoccur. An international review conducted by the Canadian Federation of Nurses Unions reveals that this was a mandatory standard applied in Hong Kong. The supply should be funded by MLTC, or the MLTC can directly provide PPE to the Home.

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

Rationale: If workers cannot access the PPE they need, they are not safe, and neither are residents. Resident care needs can change at any time, meaning workers need access to PPE at all times.

29. The Home will provide weekly updates on its supply during the pandemic to the Joint Health and Safety Committee (“JHSC”) and trade unions. This weekly update will include the number of each type of PPE (including relevant model numbers of N95s). After the pandemic, the Home will report on its supply at every JHSC meeting.

Rationale: Providing weekly updates on supply ensures transparency and allows the Internal Responsible System to function. Under Directive 5, employers and unions have obligations to

monitor supply and usage, ensure that the supply is actively replenished as needed in advance of supplies running low, and engage in joint contingency planning if supplies run low. For example, the contingency planning could include considering alternatives such as re-usable respirators that ensure equivalent or greater protection. These obligations cannot be met if workers are not provided information about supply.

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

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

31. The “Field Hospital” model which was so successful in Windsor should be used province-wide. In the alternative, LTC Homes must move residents into the hospital or dedicated facility for treating COVID-19.

Rationale: Moving infected residents out of the Home to a field hospital or similar facility allows positive and symptomatic residents to be properly isolated – something most Homes lack the facilities to do. The positive and symptomatic residents received the care they deserved at the well-staffed field hospital. With so many Homes desperately understaffed, reducing census allows the remaining staff in the Home to provide proper care to the residents who remain negative.

ENFORCEMENT

A. General

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

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

B. Ministry of Labour

33. Immediately, Ministry of Labour inspectors must:

- a. Conduct all inspections in-person, on-site.**
- b. Speak to the workers, including the worker, if any, who made the call to the MOL identifying concerns.**

- c. **Exercise independent judgment and decision-making during the inspection process**
- d. **Explain their rationale for not issuing an order in the Field Visit Report.**
- e. **Complete their investigations in a timely manner, particularly those being conducted in response to notice under s.51(1) of OHS Act (critical injury or death.)**

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

34. Inspectors must inspect so as to fully enforce the Act and the standards set in the Directives.

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

35. The MOL should conduct a proactive inspection blitz in LTC Homes, which would include unannounced inspections. As part of the blitz, inspectors will inspect to ensure the internal responsibility system including the JHSC is functioning with regular meetings, that all policies, measures and procedures required under the Act are in place, that they have a sufficient supply of PPE, all staff are trained in the use of PPE and the Homes are acting in accordance with the precautionary principle.

Rationale: Proactive, preventative action is required to prevent future harm to workers. In many cases, MOL inspectors are not called until after an outbreak has been declared and workers have already become sick from workplace transmission. As we enter a Second Wave of COVID-19 in Ontario, it is important that the MOL ensure that every LTC workplace is in full compliance with the *Occupational Health and Safety Act*, and has all the necessary equipment and procedures in place to keep workers safe in a Second Wave. A functioning JHSC is an essential component of workplace safety. The SARS Commission recommended that “in any future infectious disease outbreak, the MOL take a proactive approach throughout the outbreak to ensure that health workers are protected in a manner that is consistent with worker safety laws, regulations, guidelines and best practices.”²² It is time we implement this long overdue recommendation.

C. Ministry of Long-Term Care

²² Ontario, & Campbell, A.G. (2006). *Spring of Fear: The SARS Commission final report*. Toronto: SARS Commission, Vol. 1, p. 49

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

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

MENTAL HEALTH

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

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