http://champlainfamilycouncils.ca

December 9, 2020

The Honourable Frank N. Marrocco, Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner
Ontario's Long-Term Care COVID-19 Commission
24th Floor, 700 Bay Street,
Toronto, ON
M5G 1Z6

Dear Commissioners,

As a volunteer network that represents and supports Family Councils in the Champlain Region we are pleased to respond to the Commission on behalf of the region with our submission.

The Champlain Region comprises about 10% of the Long-Term Care homes and 10% of the beds in the province. As you know Champlain Region was one of the hardest hit with high infections and deaths during the first wave of the pandemic. With the second wave upon us we are concerned that we not repeat this disturbing distinction.

We want to thank the Commission for issuing early recommendations to Minister Fullerton. These recommendations acknowledge the critical needs and urgency for change in long-term care homes.

Thank you for your consideration of our submission which includes input from Family Councils and family members from across the Champlain Region. Know that we are available to discuss this submission or any of our suggestions at your convenience.

Sincerely

Rosemary Cavan
Chair
Champlain Region Family Council Network
Email: crfcnottawa@gmail.com Telephone 613 828-4787

c.c. Premier Doug Ford
Minister C. Elliott
Minister M. Fullerton
Champlain Region MPPs
Samantha Peck, CEO, Family Councils Ontario

Together change can happen!

Champlain Region
Family Council Network

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

December 9, 2020

TABLE OF CONTENTS

WHO WE ARE:

The Champlain Region Family Council Network (CRFCN) represents and supports Family Councils across the Champlain Region. Our submission incorporates observations and insights received from Family Councils as well as from the families and friends of residents who are accommodated in the 60 long-term care homes in the region. The Champlain Region stretches from Deep River in the west, Hawkesbury in the east and includes the Municipality of Ottawa.

The CRFCN's objective is to assist Family Councils and advocate for improvements to the quality of care in long-term care homes that would permit residents to live in a safe, home-like environment where they are respected and can live with dignity and purpose.

The management profile of the 60 homes in this region is as follows;

- 24 homes are managed as not-for-profit homes,
- 8 homes are managed as municipal homes, and
- 28 homes are managed as for-profit homes.

These 60 homes represent approximately 10% of the total homes across the province and 10% of the total residents. Seventy-two percent of the homes in our region experienced an outbreak. As of November 23, 2020, local homes accounted for 15% of the deaths in LTC in Ontario.

We, along with local Family Councils and family members, have advocated on behalf of the residents of these homes for too many years without seeing substantive change. We have repeatedly pleaded with Ontario governments, and on occasion the federal government, to address the systemic problems in LTC: chronic understaffing; poor compensation and working conditions for front-line staff; the need for more beds to address a growing seniors population and rising rates of dementia; the replacement or redevelopment of older homes to eliminate shared rooms and meet modern building standards such as fire safety and temperature controls; supporting person-centred care which places emphasis on the emotional well-being of residents; and doing away with a climate of profit and excessive documentation taking precedence over care.

Those of us who have been involved in advocating for quality, person-centred care in long-term care know that the ravages of the pandemic in these homes can be directly traced back to these long-standing issues.

On at least four occasions, we have presented these concerns to the Standing Committee on Finance and Economic Affairs as part of their pre-budget consultations (https://tinyurl.com/yyfbs3ux). We have advocated for better care, investment in staff and capacity planning through regular meetings with our regional MPPs and countless letters to provincial Ministers under both Liberal and Conservative governments. We have also reached out to the federal government, most recently on the need for national standards. Our latest set of recommendations (https://tinyurl.com/y5kwazgj) was recently sent to our local MPPs which includes the Minister of Long-Term Care.

We have taken the liberty of modifying our submission format to present our findings under specific subjects. Under these headings where appropriate we have identified what worked and what didn't work and have included recommendations for improvement. A summary of the recommendations appears at the end of the document. These comments and recommendations reflect feedback from Family Councils in our region and our observations during the course of the pandemic.

STAFF IN LONG-TERM CARE HOMES

Issues that were problematic:

- Current statistics show that 90% of residents in LTC homes today have some type of cognitive impairment and 40% of the residents exhibit aggressive behaviours requiring a higher level of care. This demanding resident profile has exacerbated long-standing staffing shortages creating an unstable platform for homes to take on the COVID-19 pandemic.

- Homes went into the pandemic with serious staffing shortages. The issue of retention and recruitment of LTC staff was identified in the Gillese Inquiry and was the subject of a Ministry Staffing Study (July 2020). Annually 25% of PSWs leave due to poor working conditions, compensation and benefits. These departures result in more individuals leaving the profession than graduating from training programs and there seems to be no coordinated response from the government or colleges to correct this situation.

- Pre-pandemic, the staffing shortfall was partially offset by the assistance of visiting family members and friends, paid caregivers and volunteers. Research estimates that as much as 30% of care in LTC is provided by family caregivers. Family members help with all aspects of residents' physical and emotional care and frequently help with translation. However, when lockdowns were imposed this safety net disappeared. As a result, the demands on staff were significantly increased and many residents' basic needs went unmet.

- Chronic understaffing worsened during the pandemic with some homes experiencing a 50% decrease in staffing levels due to illness, fear, limiting part-time staff to one home, child care responsibilities, and fear of catching the virus. One family member reported that her family member's home was operating with two PSWs providing care for 45-47 residents. This is an unacceptable level of care.

- Homes had limited options to backfill resources on short notice and frequently called in agency staff. Agency staff are unfamiliar with the residents and agencies charge a substantial premium that cuts into the LTC budgets that are already stretched. The military and hospital workers were brought in to several

homes in our region to address the critical shortage of workers. Hospitals, the Red Cross and paramedics are now helping out in the second wave. However, hospital support is more limited in the second wave.

- Several family members noted that their loved one's home would have benefitted by the presence of a social worker. The social worker would have helped address the emotional/mental health of residents during the long periods of isolation, during and after the pandemic. The position could have also facilitated communication between the home and family and helped family members deal with their stress. Social workers would have helped with the difficult conversations with families about Do Not Resuscitate orders and end-of-life care.

- When lockdowns occurred allied health professionals such as foot care nurses, dentists and dental hygienists, audiologists, physio and occupational therapists and mental health experts were not allowed to enter the home. Daily oral care provided by PSWs was neglected as they had so little time to address even the basic healthcare needs of the residents.

- Some homes hired untrained staff to help bridge the staffing shortfall. Although well-intended, this was less than desirable as it resulted in specialized equipment being improperly used and routines not being followed, putting residents at risk.

- Many families praised the dedication of front-line workers but expressed concern over staff fatigue and burn out. No effort was made to provide staff with mental health support until quite late in the first wave. Families are particularly concerned about the mental health and resiliency of staff now that we are in the second wave. One family member noted that "she can hear the mental fatigue in the voices of staff".

Positive responses experienced:

- Some homes that had a solid, permanent staff complement were able to maintain a reasonable level of staffing during the pandemic, however even these homes had to abandon some basic care requirements for residents during lockdowns.

- In one home staff helped with hair and foot care.

- Some homes immediately acted to bring in additional staff. An additional eight full-time positions were approved in one home in the region which will hopefully provide some much-needed assistance in the second wave.

- In one home the Administrator, Director of Care and office staff were seen helping out the front-line staff with the delivery of care to residents. Many homes deployed environment services and dietary staff to help with resident care.

Recommendations:

1. Immediately implement the recommendations of the Ministry Staffing Study, especially the commitment to four hours of direct care per resident per day. More staff are urgently needed now; homes cannot wait until 2024/25.

2. In order to improve the recruitment and retention of staff, compensation and benefits must be improved and staff offered full-time work. Recruitment efforts must emphasize personal suitability, including empathy, compassion and emotional intelligence as well as language and communication skills.

3. Homes should be required to maintain a full staff complement at all times to ensure that resident care is not compromised. Regular reporting of staffing levels should be mandatory and public.

4. All vacant RN, RPN, NP and PSW positions should be filled using a proper Human Resource Strategy that recognizes staff retention as a priority.

5. The Ministry must work with other ministries and with colleges to recruit and train more PSWs in order to satisfy the annual demand and meet the future staffing needs for the recently announced new LTC homes.

6. The Ministry must provide funding to allow all homes to hire a social worker. This position is particularly critical during transitions to care and to support the emotional health of residents. They would facilitate difficult conversations with residents and families about advance care planning, end-of-life care and DNR orders.

7. To avoid paying premiums for agency staff, LTC homes should have access to a pool of eligible trained resources that could be drawn on to maintain staffing levels. This pool of resources could service a group of homes without each home having to go through a lengthy recruitment process.

8. Allied health professionals that provide foot care, oral hygiene, audiology, physio/exercise, eyecare, and mental health professionals must have access to the home during lockdowns, with appropriate safety precautions.

RESIDENT CARE

Issues that were problematic:

- The world of residents was turned upside down during this pandemic. Individuals were restricted to their rooms all day including meal times, with no family visits and no opportunity for activities or access to fresh air. The isolation took an incredible physical and emotional toll on residents. Many family members feel the

prolonged stretches of isolation and the lack of family contact resulted in a number of “death from loneliness” cases.

- There was no quality of life for residents, and in some homes, even basic care needs were not met. Many residents suffered malnutrition and dehydration. A family member noted that her mother lost 23 pounds because she wasn’t there to prompt her to eat and drink. Those residents with dementia lost their lifeline during lockdowns without family members to reorient them – they became locked into their dementia as they slowly declined.

- Personal grooming was severely compromised during the pandemic. During lockdowns, many residents only received sponge baths in their rooms rather than being taken for a proper bath. This is unacceptable when lockdowns ran from 14 – 50 days. Too often, baths of any type were skipped. Despite Public Health directives restricting residents to their rooms, hallways could have been easily cleared to permit access to and from the bathing rooms. Residents wearing incontinent products should have showers or tub baths at least one a week.

- It was an extremely confusing time for residents, many of whom could not understand why they were restricted to their room without visitors. They felt abandoned by their family. Many residents did not recognize staff in their PPE and there was unease with new staff during this time. Many families felt that there wasn’t a protocol to introduce new staff and provide them with a clear understanding of the residents’ care needs and establish a rapport.

- Academic research has shown that over-crowding in 3 and 4 bed wards was one of the major causes of infection spread. In many cases, infected residents were not removed from their rooms to isolate them from their uninfected roommates. Residents in shared rooms were not only more vulnerable to the spread of the virus but were restricted to inhumane living conditions when isolation measures were imposed for periods that ranged from 14 days to over 50 days in some homes.

- The limited space in shared rooms coupled with fixed windows and the lack of air conditioning created an unsafe and depressing environment that was devastating to the health of the residents. Residents endured these conditions day after day without relief. Most residents were not given the opportunity to go outside or to a separate room for some solitude or short period of entertainment with a radio or a television.

- There were inconsistent practices in different public health units in our region. Some homes were told they could not send COVID positive residents to the hospital because there was concern about hospital over-crowding.

- It bears repeating that during lockdowns, residents did not have access to dentists, dental hygienists, foot care nurses, and other allied health

professionals. Foot care nurses often discover pressure ulcers, which left untreated, can lead to serious infections. Lack of dental care over eight months also had serious health consequences. A family member, who was finally able to return to the home, realized that her husband had two cavities and bleeding gums. One family member who took their family member out of LTC during the first wave discovered his toenails were so long they were curling under, causing discomfort and reducing his mobility. Loss of hearing aids, a chronic problem in LTC, resulted in even more isolation among residents with hearing problems.

- The loss of pastoral care and other counselling services to address psychological welfare and mental health of residents was identified as an issue.

- LTC management in some homes did not respect the rights and responsibilities of Essential Caregivers/Substitute Decision Makers. Several family members reported that in some homes there has been an increase in the use of anti-psychotic medication for depression and anxiety brought on by lack of family visits and unfamiliar faces behind masks. Over-medication leads to excessive sleepiness, increased falls, and other side effects in residents. Families were not always consulted over medication changes or aware of the medication prescribed for a resident.

- Too many residents went through the first wave of the virus and/or died alone because staff didn't understand guidelines that permitted family visits for palliative residents.

- In one home residents were relocated to create an isolation area. This resulted in residents who had developed friendships and strong bonds being separated at a difficult time. These individuals were relocated to other floors and visiting was not an option. It was difficult enough for the residents to deal with the restricted movements within the home but to lose your limited social network becomes devastating when your world has become so small.

- One resident enjoyed taking himself to and from daily exercise classes prior to COVID-19 and participated in most activities offered. This individual looked forward to interactions with other residents and staff and, via telephone, with family and friends. After four and a half months of lockdown his individual care needs have drastically increased. He now has no physical strength and cannot get around even with a walker. He no longer can comprehend the use of his TV remote or the telephone, and has lost the ability to read or write. He has difficulty holding a thought and has great difficulty speaking. He has demonstrated signs of frustration, anger, fear, confusion, mistrust and great despair and depression. He is not the same man after being kept in isolation for four and a half months.

Positive responses experienced:

- In some homes the allied health professionals and third-party services such as hairdressing were permitted in after the lockdowns ended but this has not happened across all homes.

- Some homes added activity staff to increase mental stimulation for residents. In some cases, the homes were able to secure donations of tablets to facilitate virtual family visits.

- Some homes found innovative ways of helping residents during isolation. These included playing music in the hallways or when not in isolation, bringing the residents outdoors.

Recommendations:

9. Residents cannot be put into lockdown and confined to their rooms for weeks on end. There must be some stimulation provided to residents in order to maintain their physical and mental abilities, including access to the outdoors, weather permitting.

10. Planning for future pandemics must recognize the role of Essential Caregivers in maintaining the physical and emotional health of residents. The government took too long to accept the guidance of recognized health experts about the important role of families in LTC.

11. An immediate plan needs to be developed and implemented to support the psycho-social and spiritual needs of residents and staff.

12. Homes need to educate new staff on the principles of person-centred care to promote both emotional and physical wellbeing, and on the importance of becoming familiar with a resident's history and care/treatment plans before taking on his or her care.

13. Families need to be assured that the care plan for their loved one is being followed and that any modifications to care or medications are reviewed and approved by the Power of Attorney. Surely, a technological solution could be found to allow family members access to some resident information?

14. A reasonable standard of personal care that will be provided to residents during lockdowns should be defined. This will eliminate some of the unacceptable situations that occurred with bathing, diaper changes and personal grooming.

15. Should relocations be necessary for infection prevention, staff need to be mindful of the relationships and strong bonds established between residents before taking any action. When a relocation is the only alternative, staff should

make every effort to create opportunities for residents to communicate, see and visit with their friends in any safe manner possible.

LEADERSHIP AND COMMUNICATION:

Issues that were problematic:

- Lack of transparency and clear up-to-date information from the home, was a consistent message we received from family members. During outbreaks, families were overwhelmed with fear and worry about the physical and mental health of their loved one but too often calls and emails went unanswered. Some family members only learned of an outbreak at a home via the media.

- Families were frustrated with the different interpretations they received from home administrators, directors of care and front-line staff on the regulations and directives as well as for how daily procedures were to be carried out. “Ask five staff members and get five different interpretations”. Particularly problematic were the differences in how Essential Caregivers were defined. Some homes resisted admitting Essential Caregivers to the home due to misinterpretation of the directives. Some family members felt they were perceived as an inconvenience and that they were only there “watching” to see if procedures are followed.

- Communication about DNR orders has been a long-standing issue. Essential Caregivers have not always been included in the decision-making process for their loved one or in meaningful conversations on the DNR criteria either when a loved one is being admitted to a Long-Term Care home or being sent to a hospital. The pandemic exacerbated the issue.

- Some Administrators refused to recognize that their home was in trouble despite it being obvious to most family members that they didn’t have the staff and other resources required to provide the most basic needs of residents. Trust was broken and families questioned whether the home could effectively manage the outbreak and fully care for the residents.

- Families at a local for-profit home requested that the military be deployed to assist with an obvious staffing shortfall. The home rejected this proposal claiming the residents would be frightened with the presence of the military and indicated that “they had it covered”.

- Family suggestions for improvement were challenged or ignored.

- There was no consistency with respect to the lockdown of a LTC home. Rather than isolating a wing of the home, or a floor, many homes locked down the entire

building or complex of buildings when one staff member or resident tested positive.

- There was no mechanism during the first wave for sharing best practices to avoid repeating the same mistakes. Some homes are repeating the same mistakes in the second wave that they made in the first.

- The absence of a dedicated social worker in most homes in the region was noted as being problematic.

- In some homes, when visiting finally resumed, families were not shown how to properly wear PPE despite there being a staff video available.

Positive responses experienced:

- In the Champlain Region the LTC Liaison Committee previously established by the LHIN, was used to share information, concerns and interpretations of Ministry guidelines. This Committee met regularly via Zoom shortly after the pandemic was declared. Regular briefings were received from Public Health Ottawa and the Hospital Command Table set up by The Ottawa Hospital to address the pandemic and coordinate support for local LTC homes. The CRFCN has a representative on this committee.

- Some administrators acted quickly to “lockdown” their home and limit staff to working at one home in advance of Ministry directives. Some homes also acted quickly to hire and train additional staff.

- Some homes provided efficient and effective leadership within the home and established clear communication channels with families. For instance, some administrators held Zoom meetings and virtual town halls with families and Family Councils; managers and guest speakers were sometimes invited to the zoom calls. Relevant information was posted in a timely manner on the home’s website.

- Homes with social workers were in a better position to provide families with information about the home’s response to the pandemic and the condition of their loved one. This permitted the administrator, director of care and front-line staff to focus on resident needs and their increased workload.

- Homes that had strong Family Councils had a solid working relationship with the home administrators, director of care and social workers. This was beneficial for the home, Family Councils and family members and resulted in an organized flow of information as regulations were introduced and modified. This permitted family and friends to be kept abreast of changing measures without having to chase staff and obtain conflicting interpretations.

- In one home, the Family Council was asked to review draft communications before they were distributed to families. Opportunities such as this strengthened the relationship between the home, Family Council and family members.

- Some homes provided staff to arrange indoor and outdoor visits. One home used a volunteer from their Family Council to remotely arrange family visits which freed up staff for other important duties.

- Some staff and administrators provided logical reasons for pandemic measures being imposed. This provided comfort to the family and friends while some obtained no information or explanation.

- Some homes sent out guidance and instructions to families on how to communicate with staff, while others sent out daily or weekly updates to families. Families indicated they appreciated it when administrators and staff provided the rationale for pandemic measures being imposed.

Recommendations:

16. Leadership training for home administrators should be reviewed to ensure that administrators have the management and communication skills to manage a crisis. The training should emphasize person-centred care and the importance of families in supporting the physical and psychological well-being of their loved ones.

17. The Long-Term Care Act, that introduced the concept of Family Councils should be strengthened from a “may have” to a “must have” requirement. Having a Family Council for each home has been proven to benefit the home, families and residents.

18. There needs to be a mechanism to share best practices and approaches to delivering care in all homes within the province, especially in crisis situations.

19. Clarification of the role of Essential Caregiver must be addressed to permit these individuals access during lockdowns. The Essential Caregiver rights must be included in the Long-Term Care Act and, when the EC is also the Substitute Decision Maker/Power of Attorney, the rights must parallel the rights of the resident that they represent.

20. Clear direction must be provided to homes when responding to an outbreak. If a wing or floor can be closed to isolate the virus, this would be an improvement over the entire building or complex of buildings being locked-down.

21. Formalize and fund the position of social worker for all homes or a grouping of smaller homes. These individuals would help support the mental health of residents. They would act as the home’s focal point and direct link between

Family Councils and family members to relay new directives and regulations and ensure proper interpretation and consistent messaging from intake of a resident to end-of-life programs.

BUILDING CONDITIONS AND DESIGN

Issues that were problematic:

- The aging facilities in our region still accommodate a number of residents in two, three and four-person rooms. These three and four-person wards do not meet the current building standards and fall far short of what a modern facility should provide. We cannot wait until 2025 to eliminate these rooms.

- Older long-term care homes do not have extra space to permit isolating residents who are contagious or require palliative care or space that could be used as an activity or entertainment area that could be used during lockdowns.

- Most homes do not have air-conditioned rooms nor are there any areas in the home fitted with a negative air pressure system similar to acute care hospitals. This needs to change.

- Most homes have limited Wi-Fi capabilities which restricted the ability of family members to maintain regular contact with their loved one.

Positive responses experienced:

- Some homes acted quickly to remove an infected resident from a shared room but this varied by home.

- Stopping admission to 3 and 4 bed rooms and maintaining homes with the existing resident capacity was essential albeit late when this instruction was issued.

Recommendations:

22. We have a moral and humanitarian obligation to eliminate multi-bed wards. LTC building standards for new or redeveloped homes must be revised to eliminate all shared rooms so that the standard is single rooms with ensuite bathrooms; to ensure sufficient space to isolate residents in the event of widespread infections; and, most importantly, create home-like environments for person-centred care. We are encouraged by a recent announcement about a new home in Sudbury that will have only single rooms.

23. Delay opening up the admission process to fill vacant beds and take advantage of the reduced capacity of residents to undertake some of the necessary renovations.

24. All homes should have multi-purpose rooms that can be used for palliative care, isolations during outbreaks or as mini-exercise or activity room during lockdowns. These multipurpose rooms should be refit with a negative air pressure system.

25. Air conditioning and ventilation systems in LTC homes must be greatly improved. Acute care hospitals have negative air pressure systems in their rooms to reduce infections. This should be required in LTC.

26. Windows that open should be mandatory. Fresh air has been shown to reduce COVID transmission in indoor spaces. There is a psychological benefit for residents to smell and hear the outdoors.

27. Funding should be provided to ensure that WiFi is freely available to all residents, family, Essential Caregivers and staff.

INFECTION CONTROL

Issues that were problematic:

- Homes had to struggle to secure sufficient PPE (many buying at inflated market rates). What supplies were available were rationed at a number of homes for front line staff. These individuals were required to reuse or improvise while performing their duties.

- Some homes did not provide staff training on the use of PPE or did not monitor staff to ensure that PPE was being used and used correctly. At some homes no proactive measures were taken to measure or record staff temperature on entry and departure from work.

- In some homes proper screening and entry procedures were not put in place. For example, staff signing in were not provided with sanitized pens and separate pen holders for clean and used pens were not provided. Also, staff temperatures were taken and the entry questionnaire used AFTER staff passed the vestibule and BEFORE staff were required to put on their masks and use hand sanitizer. Family Council asked for corrections to these errors.

- Most homes lacked an infection control specialist and staff did not have sufficient training and awareness of infection control procedures. One staff member hugged a resident but would not permit the resident to get within six feet of the his/her family member.

- There does not appear to be an emergency preparedness plan or a requirement to conduct simulation exercises to prepare LTC homes for a pandemic. This lack of preparedness resulted in a “learn as you go” approach rather than permitting homes to implement and follow a proven plan.

- “Decanting” ALC patients from the hospital to LTC at the beginning of the pandemic was problematic. This potentially could have introduced COVID into the home; it also put these new residents at risk and added pressure on the already stressed resources in homes.

- A number of individuals reported that infected residents were not isolated which contributed to high infection rates.

- Some families believe that there were unreported COVID-19 deaths among residents who died without being tested.

- Some homes did not understand or use procedures for deep cleaning in areas where COVID-positive staff worked and for quarantining deliveries to the home.

Positive responses experienced:

- A few homes appear to have had infection control procedures and a good appreciation of the protocols to be followed which positioned them well during the pandemic.

- Early in the first wave, Kingston Public Heath responded to the challenge by redirecting some Public Health inspectors that normally inspect restaurants to look at cleanliness and infection control procedures in long-term care homes. These individuals also provided training and follow-up with the homes.

- Some administrators and their staff did an exceptional job at keeping COVID -19 out of their home.

Recommendations:

28. Ensure all homes of a certain size have an infection control specialist on-site, and require smaller homes to have agreements with hospitals for infection control support.

29. Require that all LTC homes have an infection control plan which includes adequate staffing, training, PPE, and infection control policies and procedures. These plans must be regularly reviewed and updated. Infection control and simulation exercises should be incorporated into an enhanced training program for all homes and staff.

30. Ensure the participation of Family Councils and Resident Councils in pandemic and emergency preparedness planning for the home.

31. Require that annual inspections include a review of the home's infection control plan and staff knowledge of the plan.

INSPECTION PROCESS

Issues that were problematic:

- Lack of comprehensive on-site inspections before the pandemic did not properly position home to address shortcomings.

- Inspections conducted over the phone during the first wave were ineffective and unacceptable. Homes, staff and residents missed out on the guidance and advice from having inspectors on site and involved, particularly during a pandemic.

- Family members and friends regularly see, hear and experience issues that are not in compliance with the established procedures. They wonder just how badly conditions were when they were not present during lockdowns.

- There has been inadequate corrective action and follow-up when deficiencies were identified. Homes face few consequences for non-compliance. Many homes with big outbreaks had previously been cited for infection control problems which weren't corrected. We even heard that in one local home it took almost a year from the time a severe cockroach infestation was identified until the inspectors declared it a serious issue.

- The Military identified serious deficiencies in some homes. If proper inspections had been done in previous years, these issues might have been corrected before the pandemic.

Recommendations:

32. The inspection process must be overhauled to increase frequency of inspections, impose consequences for noncompliance such as fines and loss of licenses, integrate infection control expertise and offer an ongoing evaluation and guidance role to the LTC homes.

33. Inspections must also assess the complement of staff available as well as their understanding of regulations and directives.

34. Inspections must be unannounced and inspection teams drawn from across the province so that they are not known to the home.

TESTING

Issues that were problematic:

- The confusion around testing of family and friends was and continues to be problematic. Procedures are confusing and contradictory. A few homes are providing on site tests for Essential Caregivers; however, the majority of homes are unable or refuse to provide this service because of staff availability or assumptions by the home management about the need for authorization to offer testing to families.

- Until recently there was an insufficient number of testing facilities. Family members, some of them with frail and/or with mobility issues, waited in line for hours in all types of weather conditions.

- Delays in the receipt of testing results for staff and residents (up to six and seven days and even longer) continue to be experienced. In at least two homes in Ottawa, delayed test results have resulted in serious outbreaks and resident deaths. For families, delays reduce the amount of time that Essential Caregivers can support their family member.

- A request for evidence of testing is not rigidly or consistently monitored across homes potentially resulting in the spread of the virus and lengthening of lockdowns.

- The rapid test kits continue to be promised but months have gone by without any evidence that they will be provided.

Positive responses experienced:

- A very few homes are conducting on site testing for Essential Caregivers and this is much appreciated by family members.

- The number of testing sites and the ability to book appointments was increased.

Recommendations:

35. Rapid test kits must be made available to LTC homes as a first priority in order to help manage outbreaks.

36. COVID-19 testing for Essential Caregivers must be simplified so they have more time supporting their loved one in LTC. Essential Caregivers should be tested in their loved one's home.

MINISTRY REPONSES

Issues that were problematic:

- It was unsettling to discover that long-term care homes were not taken into consideration by the Province, when plans were initially developed on how best to address the pandemic. This was not the case in British Columbia. The focus on hospitals likely caused unnecessary infections and deaths in LTC in Ontario.

- The Ministry was quite late in implementing policies that would have reduced the spread of the infection such as restricting PSWs to working in one home. Our network wrote to the Minister on April 10th with this request but the one-home restriction was not introduced until April 22th. We also asked for an immediate pay raise for front-line workers similar to what was introduced in Quebec. This was not implemented until April 24th.

- Locking out families was problematic although understandable given the state of the pandemic. This action cut family and friends off from their loved ones and was traumatic for all parties. Isolation suffered by residents has had serious consequences on their physical and mental health. It must be recognized that Essential Caregivers are a necessary member of the care team and must never be denied access to their loved one.

- While the pandemic pay increase of $4.00/hour was welcomed by front-line workers it did create some problems. It came much later than other provinces. There were delays in getting the money to homes and staff were frustrated with the long wait for their pandemic pay. In the Fall, the pandemic pay was replaced by a temporary $3.00 emergency pay increase which applied only to PSWs. This created some stress as other workers felt their work should also be recognized. It also brought PSW salaries almost to the same level as RPNs. The temporary pay increase is less than the pandemic pay but PSWs are now in similar conditions as in wave one, except they are even more exhausted than they were in the spring.

- The Ministry should have issued clearer and more consistent directives that were not prone to misinterpretation by homes, staff and families. This was particularly problematic with respect to Essential Caregiver rights and responsibilities.

- The government demonstrated a reluctance to take over the management of homes when they were clearly experiencing difficulties. We believe they waited too long to call in the military and hospital teams to provide the required assistance. The military reported that one home was down to 20% of its expected staffing levels prior to their arrival.

- A comprehensive list of homes in outbreak and their statistics were not provided by the Ministry until quite late. Family Councils Ontario and the long-term care

associations had to expend resources to maintain lists that could have been directed to other activities.

- Confusion ruled from home to home as to whether the resident testing positive for COVID-19 should be sent to the hospital or not – no clear direction was provided by Public Health Regions until well into the pandemic.

- Many homes did not have a well-defined relationship with other healthcare partners such as hospitals in their area. Establishing this relationship with all homes whether they were in outbreak or not, would have meant that lessons learned during wave one could have been passed to those homes that avoided outbreaks until the second wave.

- The government's direction to reduce the number of comprehensive inspections prior to the pandemic was disturbing. Additionally, during the pandemic inspectors were allowed to conduct inspections over the telephone. Onsite inspections would have identified the gaps and problems in the home, so that corrective action could have been taken.

- There was a lack of recognition or acknowledgement that the second wave of the pandemic would return to the long-term care homes. No efforts were directed to the critical need to recruit and train staff in preparation for the second wave or establish more robust infection control procedures.

- There was a lack of consultation and communication with families as homes prepared for a second wave. Families appreciate that the workload of home administrator and directors of care along with front line staff still remains a challenge but this is an essential step that was missed. Family and friends believe that many homes are not much better prepared for the second wave than they were for the first wave. Families doubt that some homes can manage subsequent outbreaks.

- Sufficient funding to offset COVID-related expenses has not been provided to homes to carry out their responsibilities, resulting in families and homes having to pursue a variety of alternate sources of fund-raising projects to offset budget shortfalls.

- Families expected that Ontario would initiate an aggressive recruiting and training program similar to what Quebec announced in the spring so that Ontario homes would have more PSWs to face the second wave.

- Families are frustrated and disheartened at the lack of progress in fixing long-term care. One family member noted that "Our system of long-term care is more concerned about hiding its own flaws than the welfare of the people it is supposed to care for!"

Positive responses experienced:

- The Ministry worked very effectively with Family Councils Ontario (FCO). FCO kept Family Councils regularly updated on Ministry directives and FAQs.

- The hotline established by the Ministry was appreciated by family members, as was the request, in late April, from the Patient Ombudsman for family, residents and staff to contact them about issues/concerns in LTC. We referred many family members to these resources.

- Pandemic pay provided an incentive for front-line workers to remain in the LTC sector despite the risks of possible exposure to COVID-19.

- The government required hospitals to support local LTC homes. The Champlain Region created a Long-Term Care Homes Operational Task Force which coordinated hospital support for LTC homes. It included a Support Unit which looked at communication between the home and Family Councils and family members as well as mental health support for residents and staff. Our Network had several zoom meetings with the Support Team to learn of services available to families and to offer our input into the needs of families.

- Taking the initiative to call in the military and hospitals to help high-risk homes was appreciated but it should have been done much sooner. This demonstrated recognition that homes and staff had reached the breaking point and needed help.

- Although the loss of resources in some homes was difficult when part-time staff were restricted to working at one home, it undoubtedly prevented further spread of the virus and ultimately saved lives.

- Creating the COVID-19 Commission was a very positive step and families appreciated that the Commission released interim recommendations in recognition of the crisis in LTC.

Recommendations:

37. Launch a mandatory program that requires partnerships be established between all LTC homes and other health partners in the Healthcare Sector. This creates a team that will be there to work in lock step with the long-term care homes on a regular basis and when adversities arise.

38. Establish benchmarks, accountability and reporting requirements that clearly identify when staffing falls below mandated levels. This would alert the Ministry that immediate measures must be taken by the home to increase staffing or request other resources such as hospital workers, the Red Cross or the military.

Technological solutions should be explored to reduce the documentation burden on staff.

39. Recognize the rights of Essential Caregivers in the Long-Term Care Act; that Essential Caregivers are a critical part of a resident's care team and must have access to the home, even during lockdowns.

40. The effects of isolation on mental health should be better understood by LTC homes and by the Ministry. Funding must be provided for additional mental health supports, such as social workers and geriatric psychologists for LTC homes.

41. Develop a comprehensive health human resources strategy with a focus on recruiting and training of care staff especially nurses and PSWs.

42. Include family and resident voices at decision making tables.

SUMMARY OF RECOMMENDATIONS:

Our network of Family Councils appreciates the opportunity to provide input to this critical initiative. Improvements in long-term care homes are long overdue as was demonstrated during this pandemic and evident during this second wave. Hopefully with your support, changes to the LTC system will finally become a priority and bring much needed improvements to LTC. This is the time to transform LTC fundamentally so that we can build a sector that we can proud of; that is perceived as a positive place to live and work. Residents must be put at the centre of care so they live with both quality of life and quality of care. If there is one positive outcome from the pandemic let it be a better long-term care system that would make Ontarians proud.

STAFF IN LONG-TERM CARE HOMES

1. Immediately implement the recommendations of the Ministry Staffing Study, especially the commitment to four hours of direct care per resident per day. More staff are urgently needed now; homes cannot wait until 2024/25.

2. In order to improve the recruitment and retention of staff, compensation and benefits must be improved and staff offered full-time work. Recruitment efforts must emphasize personal suitability, including empathy, compassion and emotional intelligence as well as language and communication skills.

3. Homes should be required to maintain a full staff complement at all times to ensure that resident care is not compromised. Regular reporting of staffing levels should be mandatory and public.

4. All vacant RN, RPN, NP and PSW positions should be filled using a proper Human Resource Strategy that recognizes staff retention as a priority.

5. The Ministry must work with other ministries and with colleges to recruit and train more PSWs in order to satisfy the annual demand and meet the future staffing needs for the recently announced new LTC homes.

6. The Ministry must provide funding to allow all homes to hire a social worker. This position is particularly critical during transitions to care and to support the emotional health of residents. They would facilitate difficult conversations with residents and families about advance care planning, end-of-life care and DNR orders.

7. To avoid paying premiums for agency staff, LTC homes should have access to a pool of eligible trained resources that could be drawn on to maintain staffing levels. This pool of resources could service a group of homes without each home having to go through a lengthy recruitment process.

8. Allied health professionals that provide foot care, oral hygiene, audiology, physio/exercise, eyecare, and mental health professionals must have access to the home during lockdowns, with appropriate safety precautions.

RESIDENT CARE

9. Residents cannot be put into lockdown and confined to their rooms for weeks on end. There must be some stimulation provided to residents in order to maintain their physical and mental abilities, including access to the outdoors, weather permitting.

10. Planning for future pandemics must recognize the role of Essential Caregivers in maintaining the physical and emotional health of residents. The government took too long to accept the guidance of recognized health experts about the important role of families in LTC.

11. An immediate plan needs to be developed and implemented to support the psycho-social and spiritual needs of residents and staff.

12. Homes need to educate new staff on the principles of person-centred care to promote both emotional and physical wellbeing, and on the importance of becoming familiar with a resident's history and care/treatment plans before taking on his or her care.

13. Families need to be assured that the care plan for their loved one is being followed and that any modifications to care or medications are reviewed and

approved by the Power of Attorney. Surely, a technological solution could be found to allow family members access to some resident information?

14. A reasonable standard of personal care that will be provided to residents during lockdowns should be defined. This will eliminate some of the unacceptable situations that occurred with bathing, diaper changes and personal grooming.

15. Should relocations be necessary for infection prevention, staff need to be mindful of the relationships and strong bonds established between residents before taking any action. When a relocation is the only alternative, staff should make every effort to create opportunities for residents to communicate, see and visit with their friends in any safe manner possible.

LEADERSHIP AND COMMUNICATION

16. Leadership training for home administrators should be reviewed to ensure that administrators have the management and communication skills to manage a crisis. The training should emphasize person-centred care and the importance of families in supporting the physical and psychological well-being of their loved ones.

17. The Long-Term Care Act, that introduced the concept of Family Councils should be strengthened from a “may have” to a “must have” requirement. Having a Family Council for each home has been proven to benefit the home, families and residents.

18. There needs to be a mechanism to share best practices and approaches to delivering care in all homes within the province, especially in crisis situations.

19. Clarification of the role of Essential Caregiver must be addressed to permit these individuals access during lockdowns. The Essential Caregiver rights must be included in the Long-Term Care Act and, when the EC is also the Substitute Decision Maker/Power of Attorney, the rights must parallel the rights of the resident that they represent.

20. Clear direction must be provided to homes when responding to an outbreak. If a wing or floor can be closed to isolate the virus, this would be an improvement over the entire building or complex of buildings being locked-down.

21. Formalize and fund the position of social worker for all homes or a grouping of smaller homes. These individuals would help support the mental health of residents. They would act as the home’s focal point and direct link between Family Councils and family members to relay new directives and regulations and ensure proper interpretation and consistent messaging from intake of a resident to end-of-life programs.

BUILDING CONDITIONS AND DESIGN

22. We have a moral and humanitarian obligation to eliminate multi-bed wards. LTC building standards for new or redeveloped homes must be revised to eliminate all shared rooms so that the standard is single rooms with ensuite bathrooms; to ensure sufficient space to isolate residents in the event of widespread infections; and, most importantly, create home-like environments for person-centred care. We are encouraged by a recent announcement about a new home in Sudbury that will have only single rooms.

23. Delay opening up the admission process to fill vacant beds and take advantage of the reduced capacity of residents to undertake some of the necessary renovations.

24. All homes should have multi-purpose rooms that can be used for palliative care, isolations during outbreaks or as mini exercise or activity room during lockdowns. These multipurpose rooms should be refit with a negative air pressure system.

25. Air conditioning and ventilation systems in LTC homes must be greatly improved. Acute care hospitals have negative air pressure systems in their rooms to reduce infections. This should be required in LTC.

26. Windows that open should be mandatory. Fresh air has been shown to reduce COVID transmission in indoor spaces. There is a psychological benefit for residents to smell and hear the outdoors.

27. Funding should be provided to ensure that WiFi is freely available to all residents, family, Essential Caregivers and staff.

INFECTION CONTROL

28. Ensure all homes of a certain size have an infection control specialist on-site, and require smaller homes to have agreements with hospitals for infection control support.

29. Require that all LTC homes have an infection control plan which includes adequate staffing, training, PPE, and infection control policies and procedures. These plans must be regularly reviewed and updated. Infection control and simulation exercises should be incorporated into an enhanced training program for all homes and staff.

30. Ensure the participation of Family Councils and Resident Councils in pandemic and emergency preparedness planning for the home.

31. Require that annual inspections include a review of the home's infection control

plan and staff knowledge of the plan.

INSPECTION PROCESS

32. The inspection process must be overhauled to increase frequency of inspections, impose consequences for noncompliance such as fines and loss of licenses, integrate infection control expertise and offer an ongoing evaluation and guidance role to the LTC homes.

33. Inspections must also assess the complement of staff available as well as their understanding of regulations and directives.

34. Inspections must be unannounced and inspection teams drawn from across the province so that they are not known to the home.

TESTING

35. Rapid test kits must be made available to LTC homes as a first priority in order to help manage outbreaks.

36. COVID-19 testing for Essential Caregivers must be simplified so they have more time supporting their loved one in LTC. Essential Caregivers should be tested in their loved one's home.

MINISTRY RESPONSES

37. Launch a mandatory program that requires partnerships be established between all LTC homes and other health partners in the Healthcare Sector. This creates a team that will be there to work in lock step with the long-term care homes on a regular basis and when adversities arise.

38. Establish benchmarks, accountability and reporting requirements that clearly identify when staffing falls below mandated levels. This would alert the Ministry that immediate measures must be taken by the home to increase staffing or request other resources such as hospital workers, the Red Cross or the military. Technological solutions should be explored to reduce the documentation burden on staff.

39. Recognize the rights of Essential Caregivers in the Long-Term Care Act; that Essential Caregivers are a critical part of a resident's care team and must have access to the home, even during lockdowns.

40. The effects of isolation on mental health should be better understood by LTC homes and by the Ministry. Funding must be provided for additional mental health supports, such as social workers and geriatric psychologists for LTC homes.

41. Develop a comprehensive health human resources strategy with a focus on recruiting and training of care staff especially nurses and PSWs.

42. Include family and resident voices at decision making tables.

Together we can make change happen…